**Facial Consent Form Template**

**Current Skin Care Routine**

Do you cleanse tone moisturise daily?

Do you wear SPF25+ daily?

Do you use any face creams day or night?

Are you currently under the dermatologist or awaiting treatment for skin related problems?

Do you take any medication?

Name:

Address:

Date Of Birth:

Contact Number:

Email Address:

Doctor Surgery & Contact Number

Please tick if any of the following apply to yourself:

Smoking Sunbeds Cold Sores Hay Fever Migraines Bruising Diabetes Acne Psoriasis Dermatitis Conjunctivitis Stiffness or aches and pains to the neck or shoulders Back Pain Facial Scars Haemophilia Taking Anticoagulants Roaccutane/Accutane Epilepsy or seizures

I agree that the information I have provided is correct to the best of my knowledge.

I understand the service being provided and the aftercare that is needed to keep the service at its best.

**CLIENT SIGNATURE..................................................................................................**

**PRINT NAME............................................................................................................**

**THERAPIST SIGNATURE.............................................................................................**

**THERAPIST NAME.....................................................................................................**

**DATE.......................................................................................................................**

WHAT ARE YOUR PRIMARY SKIN CONCERNS?..........................................................................................................................................................................................................................................................................................................................................................................................................

WHAT ARE YOUR EXPECTATIONS OF THE TREATMENT? .......................................................................................................................................................................................................................................................................................................................................................................................................

Have you had any of the following treatments?

Botox Dermal Fillers Profhilo Skin Boosters Microneedling Laser facial services Laser hair removal to the face Chemical Peels Microdermabrasion Dermaplane Facial

If yes to any of the above, please list when you last received the treatment

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