AESTHETICIAN PROFILE CARD

IZUMI
FOUNTAIN OF YOUTH

Name_____

Phone_____E-mail_____

Address_____

City_____State_____ Zip _____ DOB _____

How did you find us? Referral? ☐ By Whom?_____

Website? ☐ Ad? ☐ Angie's List? ☐ Social Media? ☐ Which Social Media Site?_____

Other:_____

Would you like to be on our newsletter list to receive specials? Yes_____ No_____

If yes, what is your email address:_____

MEDICAL:

Are your currently or within the last year under any Doctors care? Yes_____No_____

If yes, please explain_____

_____

Do you have any allergies? Please list_____

Have you ever had an allergic reaction to any skin care product or treatment? Yes_____No_____

If yes, please explain:_____

_____

Please list medication, vitamins, street drugs. List all and why: _____

_____

Do you smoke? Yes_____No_____ If yes, how long and how much? _____

Have you undergone surgery recently? Yes_____No_____

If yes, please explain:_____

_____

Do you have any medical conditions that might interfere or be a contraindication for having this treatment, such as; contagious diseases, skin rash, high/low blood pressure, cardiac or circulatory problems, metal implants, pregnancy, cancer (specifically skin cancer or basal cell treatment, any medical conditionI should be aware of? Please explain below:

_____

_____

_____

Do you exercise regularly? Yes_____No_____

How much time do you spend in the sun on average? _____ Do you use sunscreen? Yes_____No_____

Do you reapply the sunscreen as recommend by product? Yes_____No_____

Do you get your skin checked regularly for abnormalities or skin cancer? Yes_____No_____

Do you have sinus issues? Yes_____No_____

Do you wear contacts? Yes_____No_____

Do you get or currently have a headache? Yes_____No_____

Have you had any of the following within the last 6 months?

Laser Treatent_____ Augmentation/implant_____ Botox_____ Dermabrasion_____

Microdermabrasion_____ Peel_____ Resurfacing_____ Waxing_____ Tanning_____ Fillers_____

Please take the time to read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, that this treatment may be contraindicated please let me know before treatment, and consult your Physician. A referral from your primary care provider may be required prior to service being provided.

“I understand that this facial treatment m ay include massage to the face, neck and décolletage, hands, arms, and feet. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the service can be adjusted or discontinued. I understand that this service should not be construed as a substitute for

medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of having. I understand that the aesthetician makes neither claims nor allegations to take the place of medical personal, nor diagnose, prescribe, or treat any medical conditions. I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to the practitioner updated as to any changes in my medical profile and I understand that there shall be no liability on the practitioner's part should I with hold or forget to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will not be tolerated and will result in immediate termination of the session, and I will be liable for the full payment of the scheduled appointment."

Client Name Printed _____Date_____

Client Signature_____

CANCELATION POLICY:

We require a 24 hour notice for any cancellation. There is a 50% cancellation or no show fee with less than 24 hour notice. If you are 15 minutes or more late for your appointment, your service will be cut short by the amount of time you were late. If you are ill please cancel as soon as possible.