FACIAL TREATMENT
Consultation Form

CLIENT INFORMATION

Name: _____ Date: _____

Date of birth: _____ Age: _____ ☐ Female ☐ Male ☐ NB

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Emergency contact: _____ Phone #: _____

Would you like to be added to our email list for news and exclusive offers? *Yes* ☐ *No* ☐

MEDICAL HISTORY

Do you have or have you had any of the following conditions? If yes, please select them:

- ☐ Acne
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood disorder
- ☐ Cancer
- ☐ Diabetes
- ☐ Eczema
- ☐ Epilepsy
- ☐ Fever blisters
- ☐ Heart condition
- ☐ Herpes
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ Hyper pigmentation
- ☐ Hypo pigmentation
- ☐ Hysterectomy
- ☐ Immune disorders
- ☐ Insomnia
- ☐ Keloid scarring
- ☐ Low blood pressure
- ☐ Lupus
- ☐ Metal bone pins/plates
- ☐ Phlebitis, blood clots
- ☐ Seizure disorder
- ☐ Skin disease/lesions
- ☐ Seborrhea
- ☐ Thyroid condition
- ☐ Varicose veins
- ☐ Warts

Any other condition: _____

Any known allergies? ☐ No ☐ Yes: _____

List any medications you take regularly, including vitamins, herbal supplements, aspirin:

_____

Any recent surgery, including plastic surgery? ☐ No ☐ Yes, explain:

_____

♀ Are you pregnant or trying to become pregnant? ☐ No ☐ Yes

Have you ever had a facial treatment before? ☐ No ☐ Yes

If yes, please explain: _____

What would you like to achieve from your treatment today?

_____

SKIN CARE

Please Check Current Products You Use:

- ☐ Eye Make-Up Remover
- ☐ Cleansing Cream
- ☐ Facial Soap
- ☐ Skin Toner/ Astringent
- ☐ Body Soap
- ☐ Eye Cream
- ☐ Day Cream
- ☐ Night Cream
- ☐ Neck lotion
- ☐ Hand cream
- ☐ Mask
- ☐ Facial Scrub
- ☐ Exfoliants
- ☐ Body Lotion
- ☐ Body Scrub

SKIN HISTORY

What is your skin type?	☐ Normal	☐ Oily	☐ Dry	☐ Combo	☐ Unsure
Your exposure to the sun?		☐ Never	☐ Light	☐ Moderate	☐ Excessive
What type of foundation do you wear?		☐ Liquid	☐ Cream	☐ Powder	☐ None
How does your skin heal?		☐ Fast	☐ Slow	☐ Scars	☐ Pigments
Do you get bruises easily?		☐ No	☐ Yes		

SKIN CONCERNS

- ☐ Acne
- ☐ Blackheads
- ☐ Broken Capillaries
- ☐ Comedones
- ☐ Cherry Angioma
- ☐ Discoloration
- ☐ Dryness/Dull Skin
- ☐ Eczema
- ☐ Fine lines/Wrinkles
- ☐ Hyper pigmentation
- ☐ Hypo pigmentation
- ☐ Keloids
- ☐ Milia
- ☐ Oily Skin
- ☐ Psoriasis
- ☐ Redness
- ☐ Rosacea
- ☐ Scarring
- ☐ Sensitivity
- ☐ Sun Damage
- ☐ Thin Skin
- ☐ Unwanted Hair
- ☐ Other: _____

Have you ever used acne medication? ☐ No ☐ Yes

If yes, when? _____ Which drug? _____

Have you in the last 3 months used Retin-A, Renova, AHA's or Retinol/Vitamin A derivative products? ☐ No ☐ Yes, please describe: _____

Have you received Botox, Restylane, or Collagen injections in the last 6 months?

☐ No ☐ Yes, please describe: _____

By signing below, you agree to the following:
I have completed this form truthfully and to the best of my knowledge. I agree to inform the technician of any changes in the above information. I agree to waive all liabilities toward my technician and the employer for any injury or damages incurred due to any misrepresentation of my health history.

_____ _____

Client Name (printed) : *Date*

_____ _____

Client Name (signature) : *Date*

WE LOOK FORWARD TO WORKING WITH YOU!

FACIAL TREATMENT

Client Consent Form

I hereby consent to and authorize Carin Kim to perform the following procedure:
Facials/Lash Lifts/Body Sculpt

I have voluntarily chosen to undergo this treatment/procedure after the nature and purpose of this treatment has been explained to me, along with the risks and hazards involved, by Carin Kim.

Although it is impossible to list every potential risk and complication, I have been informed of possible benefits, risks, and complications. I also recognize there are no guaranteed results and that independent results are dependent upon age, skin condition, and lifestyle and that there is the possibility I may require further treatments of the treated areas to obtain the expected results at an additional cost.

I have read and understand the post-treatment home care instructions. I understand how important it is to follow all instructions given to me for post-treatment care. In the event that I may have additional questions or concerns regarding my treatment or suggested home product/post-treatment care, I will consult the esthetician immediately.

I have also, to the best of my knowledge, given an accurate account of my medical history, including all known allergies or prescription drugs or products I am currently ingesting or using topically.

I have read and fully understand this agreement and all information detailed above. I understand the procedure and accept the risks. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. I do not hold the esthetician, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this skin care procedure, which may be affected by the treatment performed today.

Client Name (printed)	*Client Name (signature)*	*Date*

Esthetician (signature)	*Date*

FACIAL TREATMENT

Photo & Video Release Form

I, _____ hereby grant and authorize Carin Kim the right to take, edit, alter, copy, exhibit, publish, distribute and make use of any and all pictures, videos and /or audio taken of me to be used in and/or for any lawful promotional materials including, but not limited to, newsletters, flyers, posters, brochures, advertisements, press kits, websites, social media sites and other print and digital communications, without payment or any other consideration.

This authorization shall continue indefinitely and extends to all languages, media, formats and markets now known or later discovered.

I waive any rights to royalties or other compensation arising or related to the use of the photograph or recording.

I understand and agree that these materials shall become the property of
and will not be returned.

I hereby hold harmless and release Carin Kim from all liability, petitions, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons may make while acting on my behalf or on behalf of my estate.

By signing below, I hereby acknowledge that I have completely read and fully understand the above release agreement.

_____ _____

Client Name (printed) : *Date*

_____ _____

Client Name (signature) : *Date*

FACIAL TREATMENT

Cancellation Policy

Our goal is to provide quality care in a timely manner. In order to do so, we have had to implement an appointment/cancellation policy.

Appointments are in high demand, and your early cancellation will give another person the opportunity to have access to timely care. This policy enables us to better utilize available appointments for our clients.

At the time of booking your appointment you will be asked to pay a $50 deposit that will be credited towards your treatment/s.

Time has been specifically reserved for your appointment, procedure, or treatment. If you need to cancel or reschedule your appointment you must call at least 24 hours prior to your appointment and your deposit will either be refunded or pushed for a future appointment. However, providing less than 24 hours' notice will require you to pay a $50 cancellation fee.

If you arrive more than 15 minutes late for your appointment it is considered a no-show and you will be charged the cancellation fee.
We are happy to answer any questions regarding this cancellation policy.

I have read and fully understand the above Appointment Cancellation Policy and agree to be bound by it's terms. I agree to pay the cancellation fee in the event of a missed appointment.

Client Name (printed) :	*Date*
Client Name (signature) :	*Date*

SKINCARE BY CARIN
www.skincarebycarin.com // 213-260-1452