PASSER RESTORATIVE THERAPIES

CLIENT CONSENT FORM

Name ____________________________________ Phone (   ) _____________ Cell (   ) ____________

Address ______________________________ City ______________________State ______ Zip _______

Email: ____ Date of Birth ___/____/______

Referred by: _______________________________________ Occupation: _______________________

What is your main concern with your skin?

____

Are you currently on birth control? Yes No

Are you now or have you ever used Accutane _____

If so, when _____________

Are you presently using (or used in the past) Differin, Renova, Retin-A Gylycolic, or Alpha Hydroxy Acids? If so, when & for how long? ________________

Are you Pregnant? Yes No

Do you smoke? Yes No

Have you had skin cancer? Yes No

What skin care products do you use?

____

Do you often experience stress? Yes No

Do you have any allergies to cosmetics, foods, or drugs? If so, what? _______________

____

Please circle if you are affected by or have had any of the following:

Asthma	*Fever Blisters*	*Hysterectomy*	*Sinus Problems*	*Cardiac Problems*
Eczema	*Anxiety*	*Herpes*	*Depression*	*Pace Maker*

I understand that the services are not a substitute for medical care and any information provided by the Esthetician is for educational purposes only and not diagnostically in any nature. I understand that the information herein is to aid the Esthetician in giving better service and is completely confidential.

Client Signature ____ Date ______________________

Esthetician ____ Date ______________________

Consent to Treatment of a Minor:

Signature of Parent or Guardian ____ Date ________________