THE VAULT SALON

FACIAL TREATMENT

Consultation Form

CLIENT INFORMATION

Name: _____ Date: _____

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

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Your Occupation: _____

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	☐ Eye Cream	☐ Mask
☐ Cleansing Cream	☐ Day Cream	☐ Facial Scrub
☐ Facial Soap	☐ Night Cream	☐ Exfoliants
☐ Skin Toner/ Astringent	☐ Neck lotion	☐ Body Lotion
☐ Body Soap	☐ Hand cream	☐ 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	☐ Dryness/Dull Skin	☐ Milia	☐ Sensitivity
☐ Blackheads	☐ Eczema	☐ Oily Skin	☐ Sun Damage
☐ Broken Capillaries	☐ Fine lines/Wrinkles	☐ Psoriasis	☐ Thin Skin
☐ Comedones	☐ Hyper pigmentation	☐ Redness	☐ Unwanted Hair
☐ Cherry Angioma	☐ Hypo pigmentation	☐ Rosacea	☐ Other:
☐ Discoloration	☐ Keloids	☐ Scarring	_____

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*

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Cancellation & No-Show 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 place a credit card on file that will be due to violation of cancellation and no-show policy. Our team will make efforts to notify you before making such charge.

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 with no penalty charge. However, providing less than 24 hours' notice will require you to pay 50% of all scheduled services.

If you np-show your appointment or arrive more than 15 minutes late for your appointment, which is considered to be a no-show, will be charged the 100% of all scheduled services.

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*