

Facial Treatment Consultation Form

The following information will be used to help plan a safe and effective treatment. Please answer the questions to the best of your knowledge. All information will remain private & confidential.

Treatment Required: Holistic Facial Beauty Facial Facial Reflexology Zone
Face Lift

Today's Date: _____ Date of Birth: _____

First Name: _____ Last Name: _____

Address: _____

Phone Number: _____ Cell Phone Number: _____

E-mail: _____

Emergency Contact Name: _____ Mobile: _____

How did you hear about me: Website Online Search Instagram Facebook
Referral Other

If Referral, please list name:

If Other, please let me know:

Your Skin

What are your skin care goals?

What are your skin care challenges? Wrinkles Fine Lines Hyperpigmentation
Sun Damage Acne Scarring Redness
Rosacea Sensitivity Aging Breakouts
Dry Flaky Excess Oil Other

Please feel free to go into more detail

Have you ever had a facial or skin treatment before? Yes No

If Yes, when?

What Skin Care Products do you currently use? Cleanser Face Wash Bar Soap
Face Scrub Exfoliants Toner
Serums Moisturizer Sunscreen
Eye Product(s) Lip Product(s)
referred Brand(s)

Do you/have you used Retin-A, Renova, Adapalene, Accutane, Differen,
Glycolic Acid, Lactic Acid, Mandelic Acid, Retinol,
or other Vitamin A derivatives

Yes, currently using Yes, but not within the last 30 days

Yes, but not within the last 6 months No Not sure

Please specify which product or type, if you answered Yes, currently using' to above.

Have you received any of these facial services in the last 30 days?

Waxing Sugaring Threading Electrolysis Laser Depilatory Cream Botox
Dermal Fillers Facial Injectables None

If yes, please confirm last date :

Your Health

Have you experienced any of these health conditions in the past or present?

Hormone Imbalance Cancer Systemic Disease High Blood Pressure Diabetes
Heart problem Arthritis Auto-Immune Disorders Asthma Epilepsy
Seizure Disorder Fever Blisters Herpes Frequent Fever Blisters
Herpes Frequent Cold Sores HIV AIDS Lupus Depression
Anxiety Hepatitis Headaches Migraines Covid- 19 Other None

If you checked yes to any of these please provide further information.

Do you? Wear contact lenses Wear hearing aids No, not Applicable

Do you take any dietary/health supplements? Yes No

If yes, please list

Any known allergies (eg: aspirin, latex, nuts, essential oils)? Yes No

If yes, please give details

Have you currently taking any prescription / over the counter medications? Yes No

If yes, please give details

Are you a smoker? Yes No Social

Do you drink more than 4 caffeinated beverages a day? (tea, coffee, soda, energy drinks) Yes No

Do you drink alcohol? Yes No

What is your daily water intake (glasses / litres)?

Have you ever experienced claustrophobia? Yes No

Please rate your stress level : Low Medium High

FEMALE CLIENTS

Are you taking birth control? Yes No

If yes, what kind

Are you pregnant or trying to become pregnant? Yes No

Recently had a baby and am breastfeeding N/A

Any menopause issues? Yes No N/A

If yes, please specify

Are you undergoing any hormone replacement therapy? Yes No

If yes, please specify

Is there any other information you would like to make your therapist aware of? Yes No

If yes, please give details:

Post Facial Advice: Direct sunlight exposure is to be avoided immediately following the treatment (including any strong UV light exposure and/or tanning beds). If some sun exposure cannot be avoided first apply a broad spectrum sunscreen of SPF 30. Facial massage, cupping and gua sha may cause temporary redness/pinking of the skin - this is a normal and positive outcome and indicates the increase of bloodflow as a result of the treatment. In areas of stagnation, cupping may cause skin markings which may last a few days, otherwise all pinking

should subside within a few hours. If you have any concerns about this please let me know prior to the treatment. Unless otherwise specified, in the evening following your treatment, cleanse your skin with a mild cleanser and water followed by a non-active moisturizer. Do not apply exfoliating ingredients / products the day of your service as over-exfoliation can result in irritation or further sensitivity. If you have any concerns post treatment please contact me. I have read the post care instructions and agree to adhere to them.

Reservation & Cancellation Policy for all current and future appointments: In the event of cancellations received less than 24 hours prior to appointment a cancellation fee equal to the reserved service booking will incur. No Shows will be charged 100%. Suspected Covid- 19 is the exception to this rule, but please do let me know asap

I understand the reservation and cancellation policies at Renew Therapies and consent to my credit card on file being charged if I fail to give the required notice.

CLIENT DECLARATION: I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. I understand that redness and other reactions may occur from facial treatments. If I experience any discomfort during the treatment. I will inform the therapist immediately, so that the products/techniques can be adjusted. The treatments I receive here are voluntary and I release the therapy from liability and assume full responsibility thereof.

GDPR Statement: In accordance with the General Data Protection Regulation, this information will be held securely by Renew Therapies for 8 years. This is standard practice and is required for insurance purposes. Please note, your personal data will remain confidential and will never be shared with a third party without your written consent. If you wish to see the data on your files, please request in writing via email to renewtherapiesdublin@gmail.com. Please confirm that you have read and agree with this statement.

I agree that my information will be held securely in compliance with GDPR requirements.

I occasionally contact clients to follow up on a session and I also send booking confirmation and a reminder via email / SMS. I occasionally send emails regarding company news, updates, special offers etc. You may unsubscribe from these marketing emails at any time. Please confirm you give your permission for Renew Therapies to:

Contact you about appointment and relevant follow up. Send occasional emails with news, special offers etc.

Signature: _____

Thank you for taking the time to complete this form Dr Sally Dong DAOM , AP 4269