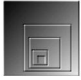 CHANGES Salon & Day Spa

To ensure a relaxing experience for our guests silence is honored in the SPA.
Please be sure your cell phone or turned to vibrate. If you need to make or receive a call,
please ask your technician to escort you out of the spa area.

Facial Service Consultation

Guest Name________________________________ Date_______________ Technician______________________

1. Have you received a facial (at Changes or other spa/salon) before? Yes No If yes, when _________________
2. Are you currently under the care of a physician/dermatologist or are you taking any medications (including topical)? Yes No Describe:____
3. Have you had a facial peel, laser, surgery, or microdermabrasion treatment in the past year? Yes No If yes, which treatment(s)____
4. Do you have a history of skin sensitivity? Yes No
5. Are you prone to breakouts? Yes No
6. Do you have any allergy to latex, medication, food, fabrics or skincare or other products or ingredients? Yes No
7. Have you ever taken Accutane? Yes No If yes, when and for how long? __________________________
8. Have you used Retin A, Renova, Retinols, Adaptalene, Tazarac or Differin in the last six weeks? Yes No
9. When was the last time you went tanning/sunless tanning? ____
10. Have you had, or do you currently have Dermatitis, Lupus, Warts, Diabetes, Cold Sores, or any contagious skin condition? Yes No If yes, are you taking medication for it?____
11. Do any of the following skin conditions apply to you (check all that apply)?

- ☐ Fine Lines
- ☐ Acne
- ☐ Sun Damage
- ☐ Large Pores
- ☐ Dryness
- ☐ Over-production of Oil
- ☐ Congestion
- ☐ Dark Spots or Hyper-pigmentation
- ☐ Dilated Capillaries, Rosacea or Spider Veins
- ☐ Psoriasis or Eczema
- ☐ Sun or Wind Burned
- ☐ Other ________________

Female Guests

12. Are you pregnant or lactating? Yes No N/A Are you trying to get pregnant? Yes No N/A
13. Are you currently on your Menstrual Cycle (can cause increased sensitivity)? Yes No N/A

Would you like to add a lip wax or customize your facial with a Collagen Crystal Mask today? Yes No

Describe your skin care routine and the products you use (cleanser, exfoliation, sunscreen, moisturizer, etc.)? _________

____

____

____

Signed ___________________________________

Technician Use - Additional questions for Add-On Peel.

Ethnicity ______________________________________ Recent Hair Removal? ______________________________

Contact Lenses__________________________________ Injectables? if yes, When, what, where?________________

Permanent Makeup - if yes, where? _______________ Smoke? _______ Caffeine? _______Alcohol? _________

Prior Peels? ____________________________________ Cold Sores/Fever Blisters? __________________________

Guest Initials that additional questions have been covered prior to add-on peel. ________________