Spa 43
COSMETIC & LASER CENTER

Client Information

Name_____

Address_____

City, State, Zip Code_____

Phone#_____ **DOB** _____

Email Address _____

Is this your first visit to our spa? _____

How were you recommended to us? _____

Have you ever had a facial treatment before? _____

Skin Type: **Oily, Combination, Normal, Dry, Sensitive, Reactive**

Main Concerns:

Acne _____	Aging _____	Sun Damage _____
Acne Scarring _____	Fine Lines/Wrinkles _____	Rosacea _____
Enlarged Pores _____	Deep Wrinkles _____	Broken Capillaries _____
Blackheads _____	Tone/Texture _____	Other _____
Whiteheads _____	Pigmentation _____	

*Have you ever head a reaction to a cosmetic or skin care product? **No Yes**
If yes, please describe:_____

*Have you had SURGERY, Botox or Restylane within the last (6) months? **No Yes**
If yes, please describe:_____

*Do you have any other medical conditions that we should be aware of?
_____

*Are you at this time taking any medication? **No Yes**_____

*Are you pregnant or breast feeding? **No Yes**_____

Client Signature _____ **Date** _____