**Esthetician Profile Card**

Name: ­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Month/Day)

Business Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Residential Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical: Are you currently or within the last year under any Doctor’s Care?

Yes\_\_\_\_\_ No\_\_\_\_\_\_

Health Issues:

\_\_\_\_Diabetes \_\_\_\_Thyroid \_\_\_\_\_Heart \_\_\_\_\_Cancer \_\_\_\_High/low Blood Pressure \_\_\_\_Epilepsy

\_\_\_\_HIV \_\_\_Hepatitis \_\_\_Pacemaker \_\_\_Asthma \_\_\_Hypoglycemia \_\_\_\_Thrombosis

\_\_\_Hormonal Disorders \_\_\_ Latex

Are you currently taking any medication? Yes\_\_\_\_\_ No\_\_\_\_

If yes please list the medication and explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you undergone treatment from a dermatologist? Yes\_\_\_\_\_ No\_\_\_\_\_

If so, what condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you undergone surgery recently? Yes\_\_\_\_\_ No\_\_\_\_

Have you recently had any Botox injections or Fillers? Yes\_\_\_\_\_ No\_\_\_\_\_

Do you have any metal implants? No\_\_\_\_ Yes\_\_\_\_\_ Explain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever experienced claustrophobia? \_\_\_\_\_No \_\_\_\_Yes

Do you smoke? Yes\_\_\_\_\_ No\_\_\_\_\_\_

Do you exercise regularly? Yes\_\_\_\_ No\_\_\_\_

Have you ever, or are you currently taking any accutane or any other acne drugs? \_\_\_\_\_No \_\_\_\_\_\_\_Yes

Date of Usage: Start\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ End\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Turn Over

Within the last 30 days have you taken or used the following Retin-A \_\_\_\_\_\_\_ Antibiotics\_\_\_\_\_\_\_\_

Diuretics\_\_\_\_\_\_\_ Laxatives\_\_\_\_\_\_\_\_\_ Alpha Hydroxy Acids\_\_\_\_\_\_\_\_\_\_\_

What is your daily consumption of Water? \_\_\_\_\_\_OZ, Coffee \_\_\_\_\_\_\_OZ, Tea \_\_\_\_\_OZ, Other \_\_\_\_\_OZ

What water temperature do you cleanse with? \_\_\_\_Cold \_\_\_\_\_Warm \_\_\_\_Hot

Have you ever experienced an allergic reaction to a skin care product? Yes\_\_\_\_\_ No\_\_\_\_\_

Or to....Cosmetics\_\_\_\_\_\_ Pollen \_\_\_\_Animals \_\_\_\_\_Metals \_\_\_\_\_Food \_\_\_\_\_\_\_Fragrance\_\_\_\_

If you answered yes to any of these please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Areas of Concern (Be Specific, Please):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you ever experience skin breakouts? \_\_\_\_\_\_No \_\_\_\_\_Yes

Personal Skin Care: \_\_\_\_\_Soap \_\_\_\_\_Cleanser \_\_\_\_\_\_Toner

\_\_\_\_\_Scrub \_\_\_\_\_Masque \_\_\_\_\_Moisturizer \_\_\_\_\_\_\_Hydrator

\_\_\_\_\_Sunscreen SPF #\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you blush easily? \_\_\_\_No \_\_\_\_Yes Sunburn Easily? \_\_\_\_\_No \_\_\_\_\_Yes

Redness Tendency: \_\_\_\_No \_\_\_\_Yes Massage Preference? \_\_\_\_Firm \_\_\_\_Light

Sinus Problems? \_\_\_\_No \_\_\_\_\_Yes Pain Threshold: \_\_\_\_Low \_\_\_\_Med \_\_\_\_High

Who referred you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your last facial? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often do you get facials?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Female Clients Only: Are you trying to become pregnant? \_\_\_\_\_No \_\_\_\_Yes

Are you due for your menstrual period within the next week? \_\_\_\_No \_\_\_\_Yes

**Release of Liability**

As client, I understand that I hold harmless Blissful Journey LLC. or any of its affiliates, the owners ,staff and therapists from any liability that may result from skin care treatment.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_