By completing this client profile, you will assist us in evaluating your specific condition. The information you provide will be used to determine what factors may be affecting you so that we may recommend the proper care.

Name:____Date:_______________

Street: ____City/State/Zip: ____________________

Email: __________________________________ Phone: ________________________

Preferred Reminder: Email/ Text/ Both Phone Carrier:_________________________

Birth Date: ______________________ Age: _____

Would you like to be added to our email list for discounts & specials? ☐ yes ☐ no

Whom may we thank for your referral? ________________________________

Health/Medical (Please answer to the best of your knowledge)

Please list all medications that you take regularly. Include hormones, vitamins, etc.:

____

____

Please circle any health conditions which you have had or are now experiencing

Cancer - Body Piercings - Epilepsy - Seizures - Lupus - Thrombosis - Phlebitis - Hemophilia - HIV

Hepatitis - Recent Illness - Light Sensitivity - Heart Problems - Pacemaker - Alcoholism

Multiple Sclerosis - Metal Implants/Screws - Hormonal Disorders - Claustrophobia - Smoking

Hypoglycemia - Asthma - Thyroid Disorders - Muscular Conditions - High/Low Blood Pressure

Diabetes - Lack of Normal Skin Sensation - Recent Surgery - Whiplash

Do you have circulation or respiratory problems? ___________

Do you have a clotting disorder? ____________

List any allergies that cause hives or anaphylactic shock:

____

List anything that may cause reactions to your skin?

____

Have you ever undergone treatment from a dermatologist? ☐ yes ☐ no

If yes, when?

____

Have you ever undergone treatment from an aesthetician? ☐ yes ☐ no

Have you ever undergone plastic surgery? ☐ yes ☐ no

Within the last month, have you taken or used any of the following?

Retin-A ☐ Antibiotics ☐ Diuretics ☐ Accutane ☐ Oral Contraceptives ☐ Laxatives ☐

If yes, when? ____

Female Clients

Are you taking oral contraception? ☐ yes ☐ no

Are you pregnant or trying to become pregnant? ☐ yes ☐ no

Are you lactating? ☐ yes ☐ no

Male Clients

Do you have any shaving challenges? ☐ yes ☐ no

If yes, please specify: ____

All Clients

On a scale from 1 (low) to 10 (high), how would you rate your stress level? ________

What are your specific concerns/challenges with your skin?

____

What is the primary reason for receiving your service today?

____

How often do you receive the service you are here for? ☐ regularly ☐ seldom ☐ never

What skin care products are you currently using?

Face: ☐ soap ☐ cleanser ☐ toner ☐serum ☐ moisturizer ☐ masque ☐ exfoliator ☐ eye products

Do you ever experience these conditions on your skin? ☐ flakiness ☐ tightness ☐ obvious dryness

Skin Sensitivity

Please answer these questions rating your sensitivity. 1 (moderate) 5 (extreme)

How sensitive is your skin? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

How much of a tendency to redness does your skin have? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

What level do you consider your pain tolerance to be? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Previous esthetic treatments, circle and date all that apply:

Dermal Fillers, Date______ - Restylane / Juvaderm / Sculptra, Date______ - Botox, Date______

Facials, Date______ - Laser Treatments, Date______ - IPL/Photorejuvenation, Date______

Chemical Peels, Date______ - Microdermabrasion, Date______ - Microcurrent, Date______

LED Light Therapy, Date______ - Oxygen Infusion Treatment, Date______

Facial Waxing, Date______

Other ____

I certify that the above statements are true and correct, and that I, ______________________________, having been advised and fully informed by ________________________________ of Fabu Face Spa concerning the nature of the process proposed, to be performed by them, and hereby authorize and direct them to perform such process and perform such services as may be deemed necessary or advisable. My signature below constitutes my acknowledgement that (1) I have read, understand, and fully agree to the foregoing (2) Understand the caution and contraindications for each process and service proposed (3) Give consent to the proposed process that has been satisfactorily explained to me and I have all the information that I desire (4) I hereby give my consent and authorization voluntarily and release Fabu Face Spa and its agents of any claims that I have or may have in the future in connection with the described application or service.

Client Signature ____Date __________________

This information is completely confidential and is used only for treatment analysis. Our policy: We requite 24-hour notice for cancellations or change of appointments. In the event of a cancellation, your card will be charged 50% of the service fee. No shows will be charged 100% of the service fee. We thank you for your understanding of our time.