SKINCARE CONSULTATION FORM

PERSONAL INFORMATION

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

DOB\_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_Male\_\_\_\_\_\_\_\_\_\_\_\_\_Female\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Please circle one, Yes or No of the following)

Would you like to receive email specials? Yes / No

Have you ever had a facial treatment? Yes / No

If Yes, when and what procedure?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a chemical peel? Yes / No

If yes, when and what peel?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had : Botox/Juvederm/Restylane/Voluma/Radlesse/Sculptra/Perlane/ Yes / No

If Yes, what kind, where injected and when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any kind of facial surgery, reconstructive surgery or dermabrasion? Yes / No

If Yes, date of surgery or dermabrasion:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had laser hair removal? Yes / No

If Yes, where and when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any skin sensitivities or allergies? Yes / No

If Yes, please identify them:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you Pregnant or Breastfeeding? Yes / No

Are you a smoker? Yes / No

Have you ever had any type of cancer? Yes / No

If Yes, what kind, treatment and date?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you get cold sores or fever blisters? Yes / No

Do you keloid or scar easily? Yes / No

Have you taken any of the following (within the last 24 hrs.) or use any products containing the following? (circle all that apply)

Isotretinoin/ Tetracycline/ Retin A/ Clindamycin/ Glycolic Acid/ Hydroquinone/ Accutane/ Antibiotics/ Blood thinners/ Advil/ Anti-Anxiety Medication/ Vitamin A over 10%

Is there anything that has not been asked that Robin Musilli needs to know about you?

Please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client/Parent or Guardian Signature Date

Robin Musilli Date

I hereby consent to authorize the use and reproduction of photos taken of me (name)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ by Robin Musilli after any eyebrow or facial procedure. Any Proofs can be used for any purpose whatsoever without further authorization from me or compensation to me. All photos shall constitute property of Robin Musilli solely and completely.

**PLEASE CIRCLE AND INITIAL ONE:**

\_\_\_\_\_\_\_\_YES, Feel free to use them. \_\_\_\_\_\_\_\_\_NO, I do not consent to use of photos.

If YES, I assign Robin Musilli to right to copyright photography.

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**INFORMED CONSENT & RELEASE FORM**

**PLEASE READ AND INITIAL:**

**\_\_\_\_\_\_\_**I have completed the Skin care Consultation Form accurately. I have been candid in revealing any conditions that could prohibit treatment(s), such as cold sores, pregnancy, use of hormones or blood thinners, recent facial surgery or laser resurfacing, Botox or fillers, use of Retin-A, Tretinoin or use of anti-biotics within the last two weeks or use of Accutane within the last 18 months.

\_\_\_\_\_\_\_I acknowledge that the possibility of an adverse reaction to a waxing, tinting, facials, chemical peels, microdermabrasion, dermaplaning, and microneedling can occur. This is the case regardless of precautions taken. I accept sole responsibility for the treatments I receive and for any medical care that may become necessary. I will immediately contact Robin Musilli after a treatment if there are any adverse reactions. In the event that I cannot reach Robin Musilli. I will immediately seek medical care.

\_\_\_\_\_\_\_I fully understand that Robin Musilli may refuse to perform the treatment(s) I have requested if a contraindication is stated. I understand that I given up substantial rights by signing this release and that it represents an agreement between me and Robin Musilli. I agree that my participation in the treatment(s) is voluntary and I accept the inherent risks.

\_\_\_\_\_\_\_I hereby release Robin Musilli and suppliers from any and all damage or injury that may result from the treatment I receive. I represent that all the information provided by me has been true and correct. I am over the age of 18 years old. I hereby authorize Robin Musilli to perform the said treatment(s).

\_\_\_\_\_\_\_Robin Musilli has provided me the information necessary for me to have made the informed decision to proceed with the treatment(s). She has answered all of my questions concerning the treatment(s). She has provided me with all the information about my treatment(s) pre and post care and what to expect during the treatment(s). I clearly understand the above the information.

Patient/Guardian/Parents Signature Today’s Date

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