Client Information

DATE:_____

RETURNING CLIENTS | Any changes since last visit? ❍ **No** ❍ **Yes** *If yes please indicate changes on form.*

CLIENT NAME: _____ **GENDER:** ❍ **M** ❍ **F** **DOB** _____

ADDRESS _____ **CITY**_____ **STATE**_____ **ZIP** _____

PREFERRED CONTACT NUMBER _____**EMAIL** _____

May we leave a message if we do not reach you personally? ❍ No ❍ Yes

WHAT ARE YOUR TOP 3 SKINCARE CONCERNS:

1. _____

2. _____

3. _____

MEDICAL HISTORY: Pregnant? ❍ No ❍ Yes Breastfeeding? ❍ No ❍ Yes

Do you smoke? ❍ No ❍ Yes

Health Conditions: _____

Past Surgeries: _____

Have you ever been diagnosed with Cancer? ❍ No ❍ Yes (last treatment date)_____

Current Medications: _____

Prescription Topicals: _____

Allergies (include aspirin & iodine): _____

PREVIOUS TREATMENTS:

Facials	❍ No ❍ Yes	Last treatment: _____	Any complications?_____
Microdermabrasion	❍No ❍Yes	Last treatment: _____	Any complications?_____
Chemical Peels	❍ No ❍ Yes	Last treatment: _____	Any complications?_____
Waxing	❍ No ❍ Yes	Last treatment: _____	Any complications?_____
Tanning	❍ No ❍ Yes	Last treatment: _____	Any complications?_____
Laser Therapy	❍ No ❍ Yes	Last treatment: _____	Any complications?_____
Massage	❍ No ❍ Yes	Last treatment: _____	Any complications?_____

SKIN CONDITIONS: *(please check all the items below that pertain to you)*

❍ Skin Infection	❍ Herpes (cold sores)	❍ Keloids/Excessive Scarring	❍ Sun Sensitivity
❍ Skin Cancer	❍ Poor Healing	❍ Tattoos/Permanent Makeup	❍ Easy Bruising
❍ Eczema	❍ Psoriasis	❍ Lymph Nodes Removed	❍ Diabetes

SKINCARE: What type of skin do you feel you have? ❍ Dry ❍ Oily ❍ Normal ❍ Combination

What is your skin routine? *(Indicate any cleansers, toners, serums, moisturizers, masques, etc.)*

1._____ 4._____

2._____ 5._____

3._____ 6._____

Osmosis Treatment Consent

CLIENT NAME: _____ **DATE:**_____

PLEASE INITIAL:

_____ I agree that the nature and purpose of the treatment has been explained to me and any questions I have regarding the treatment have been explained to my satisfaction.

_____ I understand that with any treatment certain risks are involved and that any complications from known or unknown causes could occur.

_____ I understand that possible side effects include, but are not limited to: mild to moderate redness, mild to moderate peeling or flaking, stinging, dry skin, tenderness, pimples, cold sores or allergic reactions. Most side effects are temporary and will dissipate within 3-7 days.

_____ I do not have active cold sores.

_____ I will call to inform my skincare professional of any complications or concerns I may have as soon as they occur.

_____ I understand that it is recommended prior to having a facial infusion to *not* have used Retin A for 72 hours, Accutane in 6 months or have waxed 24 hours prior to receiving treatment.

_____

CLIENT SIGNATURE PRINT NAME DATE

TECHNICIAN NOTES:

Treatment Receiving Today (check one):

❍ Medi-Facial
❍ Facial Infusion
❍ Medi-Infusion
❍ Holistic Calming Facial
❍ Holistic Stimulating Facial
❍ RevitaPen Pro Facial
❍ Other
_____
_____

Notes:

I have reviewed the treatment and post care instructions to the client stated above and answered any questions.

_____

TECHNICIAN SIGNATURE DATE

Client Product Recommendation

CLIENT NAME: _____ **DATE:**_____

CONCERN: _____

TREATMENT RECOMMENDATION: _____

_____

_____

STEP 1: CLEANSER

❍ Cleanse ❍ Purify ❍ Deep Clean ❍ Lift Away

USAGE:_____

STEP 2: MASK

❍ Polish ❍ Remedy ❍ Tropical Mango

USAGE:_____

STEP 3: SERUM

Vitamin A:

❍ Calm ❍ Correct ❍ Renew

DNA Repair / Vitamin C:

❍ Catalyst AC-11®

Growth Factor:

❍ StemFactor

Epidermal Repair:

❍ Rescue

Blemish:

❍ Clarify

Antioxidant:

❍ Replenish

USAGE:_____

STEP 4: FACIAL CONDITIONER

❍ Infuse ❍ Boost

USAGE:_____

STEP 5: EYE TREATMENT

❍ Refresh ❍ Illuminate

USAGE:_____

STEP 6: MOISTURIZER

❍ Quench ❍ Hydrate ❍ Enrich

❍ Immerse ❍ Nourish

USAGE:_____

STEP 7: SPF

❍ Protect

USAGE:_____

STEP 8: WELLNESS

❍ Collagen Activator

❍ Skin Defense

❍ Skin Clarifier

❍ Digestive Support

❍ Immune Activator

❍ Osmosis Elixirs

USAGE:_____

STEP 9: PROFESSIONAL SERVICE

SERVICE RECOMMENDED :_____

_____