AESTHETICS BY

PaigeMarie

Facial Treatment Consultation Form

Please complete this form accurately to help us provide you with the safest and effective treatment.

Client Details

Full Name: Date of Birth:

Phone: Email:

Emergency Contact:

Name: Phone:

Medical History

Please tick any that apply.

- [ ] Pregnancy or breastfeeding
- [ ] Diabetes
- [ ] Heart conditions
- [ ] Epilepsy
- [ ] Skin conditions (e.g., eczema, psoriasis, rosacea)
- [ ] Blood disorders
- [ ] Cold sores/herpes
- [ ] Allergies (please specify): _____
- [ ] Other medical conditions: _____

Are you currently taking any medications?

- [ ] Yes (please specify): _____
- [ ] No

Have you recently had any cosmetic procedures or skin treatments?

- [ ] Yes (type/date): _____
- [ ] No

Skin & Lifestyle Assessment

How would you describe your skin?

- [ ] Dry
- [ ] Oily
- [ ] Combination
- [ ] Sensitive
- [ ] Normal

What are your main skin concerns?

(e.g., acne, fine lines, dryness, pigmentation)

Do you currently use any of the following?

- [ ] Retinol / Retinoids
- [ ] Vitamin C
- [ ] Glycolic / Salicylic Acid
- [ ] Prescription skincare (e.g., acne or rosacea medication)

Are you exposed to the sun regularly or use tanning beds?

- [ ] Yes
- [ ] No

Treatment Goals

What are hoping to achieve from today's facial?

Have you ever had a facial before?

- [ ] Yes
- [ ] No

Any specific products or ingredients you know you're sensitive to?

Consent & Agreement

- [ ] I confirm that the above information is true and correct to best of my knowledge.
- [ ] I understand that results can vary and that some temporary redness, sensitivity or irritation may occur.
- [ ] I agree to follow all aftercare advice provided.
- [ ] I give consent for this treatment and for Aesthetics by Paige Marie to keep this information on file.

Client Signature:

Date:

Practitioner Name & Signature:

Date: