

KaLis Day Spa – Facials & Wax Treatments

Name: _____ Date: _____

Address: _____ City: _____

Cell Phone #: _____ Home Phone #: _____

Occupation: _____ D.O.B.: _____

Email: _____ Referred By: _____

Is this your first Facial or Wax Treatment? Yes No

What Areas of Concern do you have? _____

Are you currently under the care of a physician for any skin conditions? Yes No

Are you pregnant? Yes No Do you wear contact lenses? Yes No

Are you currently using any of the following? Azelex Differin Renova

Retin-A Tarzarc Glycolic Aha's Accutane

IMPORTANT! Please list any Allergies to Food, Drugs or Cosmetics:

Are you currently taking medications oral or topical that affect the skin? Yes No

What skin care products are you currently using? _____

Please circle if you are affected by any of the following:

- | | | | |
|-----------------------------------|---|---|---------------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> High BP | <input type="checkbox"/> Pace Maker |
| <input type="checkbox"/> Cardiac | <input type="checkbox"/> Headaches | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Skin Disease |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Lupus | <input type="checkbox"/> Sinus Issues |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Herpes | <input type="checkbox"/> Metal Pins or Plates | |

I understand that the services offered are not a substitute for medical care, and any information provided by your Aesthetician is for educational purposes only and not diagnostically prescriptive in nature. I understand that the information herein is to aid the therapist in giving better service and is completely confidential.

Client's Signature _____ Date _____