14005 N Hwy 183, Unit 1200
Suite 115
Austin TX 78717
737.239.4377
earthglow@icloud.com

Skin Care Consent Form

Have you ever had a facial before ? Yes / No | If so, how long ago ? _____

Have you had chemical peels before ? Yes / No | If so, how long ago ? _____

(If yes to either or both of the above questions):
How often do you receive skincare treatments ? _____

What type of skin do you have ?
(circle any of the descriptions below that apply to your skin):

Type	Pore Size	Temp	Texture
Sensitive	Small or Large	Hot (erythema)	Varies
Dry	Small	Cooler	Rougher/Tighter
Normal	Small	no heat	Plump/Firm
Combination	Larger in T-zone	Warm	Slightly Oily
Oily	Large	Warmer	Very Oily

What skin care products do you use ? Soap Cleanser Toner
Masque Scrub/Peel Moisturizer
Sunscreen Other_____

What temperature water do you use to cleanse with ? Cool Warm Hot

Do you have any special skin care problems pertaining to your face and/or body ? Yes / No
If yes, please explain:
_____

Have you had any reaction to any of the following ? Cosmetics Medicine Aspirin
Fragrance Sunscreen Pollen Iodine AHAs
Animals Food_____ Other_____
Do you burn easily in sunlight ? Yes / No

Do you use Retin-A ? Yes / No | If yes, how often ? _____

Do you wear contact lenses ? Yes / No

How much water do you consume daily ? _____
How many alcoholic beverages do you consume per week ? _____
How many caffeinated beverages do you consume a day ? _____
Do you smoke ? Yes / No

Are you currently seeing a physician for a specific medical reason that may interfere with this treatment ? Yes / No | If yes, please explain:

_____

Do you currently take any medications or vitamins ? Yes / No | If yes, please specify:

_____

Although every precaution will be made to ensure your safety and well-being before, during and after your skincare treatment, please be aware of the possible risks below. Please initial:

___ I am not currently taking any medications, over the counter or prescription, that would interfere with this treatment.

___ I have no current medical conditions, noted by a physician, that would interfere with this treatment.

___ I understand that additional conditions could occur or be discovered during the procedure, which could affect my ability to tolerate the treatment.

Note: Please notify your esthetician of any changes to medication, medical conditions, or any changes to the information contained in this consent form, for any and all future appointments.

I have read the above information. If I have any concerns, I will address these with my licensed esthetician. I give permission to my licensed esthetician to perform the (circle one) ***FACIAL TREATMENT, INTENSE VITAMIN C PEEL,*** *and/or* ***ADVANCED PEEL TREATMENT*** *we have discussed, and will hold her, Earth Glow LLC, and Phenix Salons + Suites harmless from any liability that may result from this treatment. I have accurately answered the questions above, including all known allergies, prescription drugs, or products I am currently ingesting or using topically. I understand my esthetician will take every precaution to minimize or eliminate negative reactions as much as possible. In the event that I may have additional questions or concerns regarding my treatment, I will consult the esthetician immediately. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read, and fully understand, the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered. I understand the procedure and accept the risks. I do not hold the licensed esthetician, whose signature appears below, responsible for any of my conditions that were present, though undisclosed at the time of this skin care procedure, which may be affected by the treatment performed today.*

Signature: _____ Date: ____/____/____

Technician Signature: _____ Date: ____/____/____

Permission is granted to take photos of my eyes face which may be used for marketing purposes:

Signature: _____ Date: ____/____/____