FACIAL TREATMENT

Consultation Form

CLIENT INFORMATION

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Gender: _____

Address: _____

City: _____ Prov: _____ Postal Code: _____

Email: _____

Phone: _____ Emergency Contact: _____

Would you like to join our email list for updates and exclusive offers? ○ Yes ○ No

How did you hear about us? _____

MEDICAL HISTORY

Do you have any of the following conditions (check all that apply):

- ○ Acne
- ○ Arthritis
- ○ Asthma
- ○ Blood disorder
- ○ Cancer/Chemotherapy
- ○ Dermatitis
- ○ Diabetes
- ○ Eczema
- ○ Epilepsy/Seizures
- ○ Fever blisters
- ○ Heart condition
- ○ Herpes
- ○ Hepatitis
- ○ High blood pressure
- ○ HIV/AIDS
- ○ Hyperpigmentation
- ○ Hypopigmentation
- ○ Hysterectomy
- ○ Immune disorders
- ○ Insomnia
- ○ Keloid scarring
- ○ Low blood pressure
- ○ Lupus
- ○ Organ Failure
- ○ Metal bone pins/plates
- ○ Phlebitis (blood clots)
- ○ Pregnant/Breastfeeding
- ○ Seizure disorder
- ○ Skin diseases
- ○ Seborrhea
- ○ Transplant
- ○ Warts
- ○ Other: _____

FACIAL TREATMENT

Are you taking any medications, vitamins or prescription drugs? ○ Yes ○ No

Any known allergies? ○ Yes ○ No

If yes, please specify: .....

Any recent surgery including plastic surgery? ○ Yes ○ No

If yes, please specify: .....

Are you pregnant or trying to become pregnant? ○ Yes ○ No

Are you taking birth control? ○ Yes ○ No

Are you undergoing any hormone replacement therapy? ○ Yes ○ No

CLIENT SKIN CONCERNS

What are your main skin concerns?

- ○ Acne
- ○ Blackheads
- ○ Dry skin
- ○ Oily skin
- ○ Dull skin
- ○ Fine lines and wrinkles
- ○ Dark circles
- ○ Dark spots
- ○ Melasma
- ○ Sun damage
- ○ Age spots
- ○ Scars
- ○ Ingrown hairs
- ○ Razor burn
- ○ Eczema
- ○ Enlarged pores
- ○ Skin redness
- ○ Thin skin
- ○ Under-eye puffiness
- ○ Uneven skin tone
- ○ Uneven skin texture
- ○ Premature aging
- ○ Whiteheads
- ○ Excessive facial hair
- ○ Skin diseases
- ○ Rosacea
- ○ Keratosis pilaris

SKIN CARE HISTORY

Have you ever had an allergic reaction to any of the following?

- ○ Cosmetics
- ○ Medications
- ○ Food
- ○ Animals
- ○ Sunscreen
- ○ Essential oils
- ○ Iodine
- ○ Nuts
- ○ Pollen
- ○ Alpha hydroxy acids
- ○ Fragrance
- ○ Skin products
- ○ Shellfish
- ○ Latex
- ○ Aspirin
- ○ Other

If yes, please specify: .....

FACIAL TREATMENT

What is your skin type?

- ○ Normal skin
- ○ Dry skin
- ○ Oily skin
- ○ Sensitive skin
- ○ Combination skin
- ○ Acne-prone skin
- ○ Aging skin
- ○ Dehydrated skin
- ○ Rosacea-prone skin
- ○ Psoriasis-prone skin
- ○ Hyperpigmented skin
- ○ Sun-damaged skin

Your skincare routine

- ○ Foam cleanser
- ○ Toner
- ○ Sunscreen
- ○ Serum
- ○ Gel cleanser
- ○ Moisturizer
- ○ Face mask
- ○ Spot treatment
- ○ Makeup remover
- ○ Eye cream
- ○ Exfoliant
- ○ Facial oil

Do you smoke or consume alcohol? ○ Yes ○ No

Have you experienced Botox, Restylane, or collagen injection? ○ Yes ○ No

If yes, please specify: .....

Have you recently received any of the following treatment?

- ○ Microdermabrasion
- ○ Lash tint
- ○ Brow tint
- ○ Micro needling
- ○ Chemical peel
- ○ Facial waxing

How much time do you spend in the sun, and what level of sun protection do you use?

.....

What are your expectations and goals for this treatment?

.....

By signing below, you agree to the following:

I have read and understand the medical questions above and have disclosed all relevant conditions. I acknowledge my responsibility to inform the technician of any changes in my medical history or health status to ensure my safety and accurate care.

Client Printed Name	Client Signature	Date
Esthetician Name	Esthetician Signature	Date

FACIAL TREATMENT

Client Consent Form

_____ I voluntarily consent to the application of a facial treatment by Cheryl Lynn's Esthetics. I understand that this procedure involves the use of various products applied to my skin to achieve desired results. I acknowledge that outcomes can vary based on my skin type, condition, lifestyle, and how well I follow the aftercare instructions provided by the technician.

_____ I confirm that I have provided accurate and complete information regarding my medical history, including any allergies or previous adverse reactions to skincare products. I understand that failure to disclose relevant information may affect the outcome of my treatment and could potentially cause complications.

_____ I acknowledge that facial treatments require proper aftercare to ensure the best results. I agree to follow the aftercare instructions provided by the technician and understand that failure to do so may result in irritation, breakouts, or other complications.

_____ I am aware of the potential risks involved with facial treatments, which may include, but are not limited to, skin irritation, allergic reactions to the products used, and, in rare cases, infection.

_____ I agree to notify the technician immediately if I experience any discomfort, irritation, or issues during or after the application of my facial treatment.

_____ I release Cheryl Lynn's Esthetics and Cheryl Lynn Colbert from any liability for reactions, complications, or damages that may occur as a result of the facial treatment. I acknowledge the potential risks and agree to seek medical attention at my own expense if complications arise. Any concerns or adverse effects will be communicated to Cheryl Lynn's Esthetics immediately.

By signing below, I confirm that I have read, understood, and agreed to all terms in this form, and I give my informed consent to proceed with the facial treatment.

Client Printed Name	Client Signature	Date
Esthetician Name	Esthetician Signature	Date

Cheryl Lynn's Esthetics
www.cheryllynnsesthetics.com
6604-316-2918

CANCELLATION

Cancellation Form

At Cheryl Lynn's Esthetics, we strive to provide exceptional service to all of our valued clients. To ensure efficient scheduling and accommodate everyone's needs, we have implemented the following cancellation policy:

1. **No-Show Fee:** If a client fails to show up for their scheduled appointment without prior notice, a fee of 50% of the service cost will be charged.

2. **Late Arrivals:** If a client arrives more than 15 minutes late for their appointment, we may not be able to accommodate the full service. In such cases, the client will be responsible for the full cost of the service.

3. **Cancellation Notice:** Clients must provide at least 24 hours' notice if they need to cancel or reschedule an appointment. Cancellations or rescheduling with less than 24 hours' notice will incur a fee of 50% of the service cost.

4. **For New Clients:** A non-refundable deposit of 50% of the service cost before GST will be required to secure an appointment for all new clients to avoid no shows and last minute cancelations. Auto deposit (no password required) Etransfers are accepted by email at cheryllynn2918@gmail.com. This fee will be applied to the final bill upon completion of your service.

5. **Repeated Cancellations:** Clients with more than 2x' of late cancellations or no-shows within a 1 year period will be required to prepay in full for future services or may be refused future bookings.

By signing below, I acknowledge that I have read, understood, and agree to abide by the cancellation policy set by Cheryl Lynn's Esthetics and I understand that these policies are in place to ensure a positive experience for all clients and Esthetician and that failure to follow this policy will result in charges or fees.

Client Printed Name	Client Signature	Date
Esthetician Name	Esthetician Signature	Date

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