

Brilliant Bodywork

CLIENT QUESTIONNAIRE

YOUR INFORMATION

Name _____ Age _____ DOB _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

MEDICATIONS

Medication	When	How Long	Medication	When	How Long
Antibiotics			Androstendione		
Accutane			Testosterone		
Benzoyl Peroxide			Progesterone		
Retin A			Thyroid		
Cream or Gel?			Gonadotrophin		
Tazorac			Danzol		
Differin			Cyclosporin		
Azelex			Lithium		
Avita			Isoniazid		
Cleocin-T			Immuran		
E-mycin-T			Disulfuram		
Copaxone			Dilantin/Tegretol		
Corticosteroids			Steroids		
Quinine			Marijuana		
Other Meds			Cocaine/Speed		

MEDICAL HISTORY – please check all that apply (use letter x to check)

Herpes Simplex		HIV/AIDS		Hemophilia	
Eczema		Thyroid Problems		Lupus	
Psoriasis		Hormone Problems		Anemia	
Hepatitis		Hysterectomy		High Blood Pressure	
Cancer		Ovary(ies) Removed		Diabetes	
Staph Infection/MRSA		Pacemaker		Metal Pins in Body	

Your primary care physician:

Name: _____ Phone: _____

Are you under a dermatologist's or other skin physician's care? Yes No

If yes, doctor's name: _____

LIFESTYLE CONSIDERATIONS

- Have you ever had any reaction to any products or anything you have put on your face? Yes No
If yes, what products? _____
- Please check any of these you are allergic to: Sulfur Aspirin Latex
List any other allergies you know of: _____
- Do you smoke? Yes No
- Do you use fabric softener or fabric softener sheets in the dryer? Yes No
- Do you swim in a chlorinated pool? Yes No
- Do you work around chemicals, tars, oils, grease or inks? Yes No
- Occupation: _____ Do you work nights? Yes No
- Are you currently under a lot of stress? Yes No (common stress = job loss, new job, wedding, romantic breakup, death in the family or close friend, graduation, difficult home life, long commute, heavily scheduled)
- Women:** Do you use birth control pills, shots or use an IUD? Yes No
If so, which do you use? _____ What brand of pill? _____
Are you pregnant or nursing? Yes No
- Men:** Do you have shaving irritation? Yes No
What do you use for shaving? _____
- Diet – do you consume the following?

Foods	X	How often per week	Foods	X	How often per week
Fast Food			Peanuts		
Processed Food			Sushi		
Salty Snacks			Kelp and Seaweed		
Milk/Yogurt			Miso Soup		
Cheese			Soy		
Whey or Soy Protein			Vitamins		
Peanut Butter			Seafood		

PRODUCTS CURRENTLY USING – Provide product names.

Cleanser	
Toner	
Serums	
Moisturizers	
Sun Screen	
Mask	
Foundation	
Blush	
Exfoliant (acids, scrubs)	
Acne Medications	
Anything Else?	

OTHER TREATMENTS: What else have you done for your skin in the last 90 days?

Glycolic/Lactic/Mandelic Peels	When?	Where?
Other Chemical Peels		
If so, what kind:		
Microdermabrasion		
Dermabrasion		
Laser Hair Removal		
Laser Rejuvenation/Resurfacing		
Skin Cancer Removal		
Facial Waxing		
Electrolysis		
Other:		

How did you hear about us? _____

What kind of work do you do? _____

How did you hear about us? _____

What results would you like to obtain with your skin? _____

ACNE TREATMENT CONSENT FORM

An acne treatment may consist of surface cleansing, mild chemical peels or steam and exfoliation, application of antibacterial serums, corrective serums and extractions. Treatments take approximately 20 to 45 minutes to complete and are designed to balance, hydrate, clear acne impactions and prepare the skin for the home care regimen. Implements and equipment used in all this facility are disposable or properly sterilized according to the State Board of Cosmetology regulations.

IMPORTANT: PLEASE READ CAREFULLY and initial

- I have not been exposed to excessive sun and my skin does not feel sensitive or irritated in any way.
- I have not had any other chemical peel of any kind, within 14 days of this treatment.
- I have not had any facial waxing, within seven days of this treatment.
- I have informed the clinic of all health problems of which I am aware, including herpes simplex/cold sores.
- I have informed the clinic of any use of oral or topical medications I may be using including Retinoids (Retin-A, Renova, Avita, Differin, Tazorac) or Accutane.
- I understand that controlling acne/problem skin is best achieved through a series of recommended treatments and compliance to the home care product program recommended by a Face Reality certified esthetician.
- I understand that I will probably not experience much visible peeling, flaking, discoloration or irritation following this procedure if I follow my homecare instructions carefully.

WARNINGS: PLEASE READ CAREFULLY and initial

- Avoid direct sunlight or tanning booths for at least three days following a treatment.
- Use of sunblock protection of at least a SPF 30 is necessary following all treatments.
- Do not pick your skin following a treatment.

PRODUCT RETURN GUIDELINES: PLEASE READ CAREFULLY and initial

- Face Reality Skin Care products are clinical-strength active formulas designed to treat problem skin conditions. Tingling sensations are normal with product application but should not be painful. If you are experiencing stinging and irritation with any product, stop using the product and call your esthetician for further instruction.
- Products may be returned within 30 days for a full refund, provided they have not been opened and/or used. If products have been opened or used it is mandatory to speak with an esthetician to obtain authorization to return that product.

RESCHEDULING GUIDELINES AND LATE POLICY: PLEASE READ CAREFULLY and initial

- A 24-hour rescheduling notice is required. We realize emergencies happen and will be considered, but reserve the right to charge a \$50.00 fee for missed appointments without a 24-hour notice. If you are more than 20 minutes late we cannot guarantee that we will be able to fit your appointment into the schedule and you may not be seen. If we cannot fit you in there will be a \$50 fee charged for the missed appointment.

I, _____, consent to photographs taken of my face to be used for monitoring treatment progress.

I hereby agree to all of the above and agree to have this treatment be performed on me. I further agree to follow all post-treatment care instructions as I am directed.

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Signature of Client: _____

Signature of Esthetician: _____

Client Agreement Form

Please initial the agreements below and sign at the bottom.

1. _____ We *must* adjust your home care routine every two weeks to keep your progress to clear skin moving forward. If we don't change how you do your home care often enough, your skin will adapt to the regimen and stop responding (in other words, you won't get clear). I agree to contact my skincare professional so we can adjust your home care regimen at least every two weeks.
2. _____ Each time we strengthen your home care, we run the risk of drying and irritating your skin, so you will need to communicate that to us if that happens. I agree to contact my skincare professional if my skin gets uncomfortably dry and irritated.
3. _____ I will not use any other products that have not been approved by my skincare professional while I am on their regimen.
4. _____ I will not change the regimen given to me by my skincare professional without notifying or consulting with them first.
5. _____ I will not run out of product while working with my skincare professional. When you stop using products (or run out) acne will start forming inside the pores and you will see it about a month later.
6. _____ I will not have other skin care treatments while I am being treated by my skincare professional.
7. _____ I will inform my skincare professional of any medications/drugs that I start taking while using their regimen.
8. _____ I will use my sunscreen every morning, regardless of whether or not I will be going outside. The sunscreen will help to keep your skin moisturized. Without it, your skin will get too dry.
9. _____ I will not get sunburned or wind burned while being treated by my skincare professional. (You will not be able to use your active products; and we will not be able to do treatments on you.)
10. _____ I will inform my skincare professional if I elect to do any laser treatments or waxing for hair removal.
11. _____ (For women) - I will inform my skincare professional if I get pregnant.
12. _____ **MOST IMPORTANTLY:** If we are unable to improve the condition of your skin due to factors beyond our control, *but within yours*, we reserve the right to decline treatments. (That is, if you are not following our instructions pertaining to home care, doing your home care, lifestyle issues, etc.)

I, _____, hereby agree to all of the above.

Date _____

SPA ETIQUETTE

It is essential that you arrive 10 minutes prior to your first scheduled appointment. This will allow you enough time to check-in, relax, complete new client intakes and enjoy complimentary snacks and infused water in our Zen Room. Please note that your scheduled time is your table time. If you arrive late, your session will end as scheduled.

- *Please Speak Softly – Brilliant Bodywork is a Quiet Healing Place
- *Please Turn Cell Phones Off in Order to Keep Serenity in the Spa
- *Please Respect Our Other Guests - Right to Solitude

Change/Cancellation/No-Show Policy

Our Therapists are highly trained professionals who are scheduled to serve you based upon the confirmed appointments you make. We kindly request that changes and cancellations be made within 24 hours of the reserved time. A second infraction will result in a cancel fee of 50% of the total service cost. Individuals who do not show up for a scheduled appointment without a cancellation will be subject to a 100% payment of the scheduled appointment. A credit card guarantee may be required for spa services.

Please note that prices and offerings subject to change without notice.

**We have been very blessed that this has not been an issue in the past and we thank you for your understanding and business.

a.) I understand that: There is a 24 hours' notice required for cancellation of an appointment, and that a fee of 50% of the cost of the scheduled service will be charged to me when this courtesy is not provided. I understand that missed appointments without a cancellation will be charged 100% of the service fee.

Initial _____ Date _____

b.) I understand that: I am to arrive 10 min before my scheduled appointment. (This prevents any stress in scheduling to you or the therapists. This also allows you time to have a fresh beverage, use the facilities, and relax before your session) You are here to relax and recover.

Initial _____ Date _____

c.) I understand that: I am to notify my service provider of any changes in my health care/Medical History.

Initial _____ Date _____

Client Name (printed) _____

Client Name (signature) _____