



Welcome to SPA ESTIQUE
NEW CLIENT INFORMATION FORM

NAME: _____ DATE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____

MOBILE PHONE: _____ EMAIL: _____

BIRTHDAY: ____/____/____ REFERRED BY: _____

Please answer the following questions to help us customize your skin treatments. Thank you.

- Are you presently using any of the following? RETIN A / RENOVA, ACCUTANE, GLYCOLIC ACID, TOPICAL VITAMIN C
Do you have any skin sensitivities or allergies? Please explain
Are you allergic to aspirin?
Are you on Hormone Replacement Therapy?
Do you use sunblock?
Do you have acne? Where is the most common area of breakout? Do the breakouts follow the menstrual cycle? What medications do you use for the acne?
Have you had any of the following? COSMETIC FACIAL SURGERY, LASER RESURFACING, CHEMICAL PEELS, BOTOX INJECTIONS, date of last Botox injection, COLLAGEN INJECTIONS, date of last Collagen injection, MICRODERMABRASION, PHOTO FACIALS
How does your skin feel first thing in the morning?
How does your skin feel during the day?
What would you like to change about your skin?
What products do you use at home?
What kind of makeup do you use?
Are presently under a doctor's care for any reason
What medications do you take on a regular basis? Please be specific.
Is there any other information I should know about your skin or your health before doing a facial treatment?

SIGNATURE: _____ DATE: _____

Thank you for taking the time to fill out this information. We look forward to serving you.