All Forms Filled Online Please Send By Email To: ab.afterglow@gmail.com

New Client Facial Treatment Consultation Form

The following information will be used to help plan a safe and effective treatment. Please answer the questions to the best of your knowledge. All information will remain private & confidential.

Today's Date *

Month Day Year

Name *

First Name Last Name

Date of Birth *

Month Day Year

Address *

Street Address

City State

Zip Code Country

Phone Number *

Area Code Phone Number

E-mail *

example@example.com

Emergency Contact Name & Mobile

How did you hear about me? *

- ☐ Website / Online Search
- ☐ Instagram
- ☐ Other

If Other,

Your Skin

What are your skin care goals? *

What are your skin care challenges? *

- ☐ Wrinkles / Fine Lines
- ☐ Hyperpigmentation / Sun Damage
- ☐ Acne / Acne Scarring
- ☐ Redness / Rosacea / Sensitivity
- ☐ Aging
- ☐ Breakouts
- ☐ Dry / Flaky
- ☐ Excess Oil
- ☐ Other

Please feel free to go into more detail

Have you ever had a facial or skin treatment before? *

- ☐ Yes
- ☐ No

If Yes, when?

What Skin Care Products do you currently use? *

- ☐ Cleanser / Face Wash
- ☐ Bar Soap
- ☐ Face Scrub / Exfoliants
- ☐ Toner
- ☐ Serums
- ☐ Moisturizer
- ☐ Sunscreen
- ☐ Eye Product(s)
- ☐ Lip Product(s)

Preferred Brand(s)

Do you/have you used Retin-A, Renova, Adapalene, Accutane, Differen, Glycolic Acid, Lactic Acid, Mandelic Acid, Retinol, or other Vitamin A derivitives? *

- ☐ Yes, currently using
- ☐ Yes, but not within the last 30 days
- ☐ Yes, but not within the last 6 months
- ☐ No
- ☐ Not sure

Please specify which product or type, if you answered 'Yes, currently using' to above.

Have you received any of these facial services in the last 30 days? *

- ☐ Waxing
- ☐ Sugaring
- ☐ Threading
- ☐ Electrolysis / Laser
- ☐ Depliatory Cream
- ☐ Botox / Dermal Fillers / Facial Injectibles
- ☐ None

If yes, please confirm last date

Month Day Year

Your Health

Have you experienced any of these health conditions in the past or present? *

- ☐ Hormone Imbalance
- ☐ Cancer / Systemic Disease
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Heart problem
- ☐ Arthritis
- ☐ Auto-Immune Disorders
- ☐ Asthma
- ☐ Epilepsy / Seizure Disorder
- ☐ Fever Blisters
- ☐ Herpes
- ☐ Frequent Cold Sores
- ☐ HIV/AIDS
- ☐ Lupus
- ☐ Depression/Anxiety
- ☐ Hepatitis
- ☐ Headaches / Migraines
- ☐ Covid-19
- ☐ Other
- ☐ None

If you checked yes to any of these please provide further information. If not mark N/A *

Do you? *

- ☐ Wear contact lenses
- ☐ Wear hearing aids
- ☐ No, not Applicable

Do you take any dietary / health supplements?

- ☐ Yes
- ☐ No

If yes, please list

Any known allergies (eg: aspirin, latex, nuts, essential oils)? *

- [ ] Yes
- [ ] No

If yes, please give details

Have you currently taking any prescription / over the counter medications *

- [ ] Yes
- [ ] No

If yes, please give details

Are you a smoker? *

- [ ] Yes
- [ ] No
- [ ] Social

Do you drink more than 4 caffeinated beverages a day? (tea, coffee, soda, energy drinks) *

- [ ] Yes
- [ ] No

Do you drink alcohol *

- [ ] Yes
- [ ] No

What is your daily water intake (glasses / litres) *

Have you ever experienced claustrophobia? *

- [ ] Yes
- [ ] No

Please rate your stress level *

- ☐ Low
- ☐ Medium
- ☐ High

FEMALE CLIENTS

Are you taking birth control? *

- ☐ Yes
- ☐ No
- ☐ N/A

If yes, what kind

Are you pregnant or trying to become pregnant? *

- ☐ Yes
- ☐ No
- ☐ Recently had a baby and am breastfeeding
- ☐ N/A

Any menopause issues? *

- ☐ Yes
- ☐ No
- ☐ N/A

If yes, please specify

Are you undergoing any hormone replacement therapy?

- ☐ Yes
- ☐ No

If yes, please specify

Is there any other information you would like to make your therapist aware of? If yes, please give details:

Post Facial Advice: Direct sunlight exposure is to be avoided immediately following the treatment (including any strong UV light exposure and/or tanning beds). If some sun exposure cannot be avoided first apply a broad spectrum sunscreen of SPF 30. Facial massage, Dermaplane and gua sha may cause temporary redness/pinking of the skin - this is a normal and positive outcome and indicates the increase of bloodflow as a result of the treatment. If you have any concerns about this please let AB AfterGlow LLC know prior to the treatment. Unless otherwise specified, in the evening following your treatment, cleanse your skin with a mild cleanser and water followed by a non-active moisturizer. Do not apply exfoliating ingredients / products the day of your service as over-exfoliation can result in irritation or further sensitivity. If you have any concerns post treatment please contact AB AfterGlow LLC. * ☐

I have read the post care instructions and agree to adhere to them.

Reservation & Cancellation Policy for all current and future appointments: In the event of cancellations received less than 24 hours prior to appointment a cancellation fee of 25% to the reserved service booking will incur. No Shows will be charged 50%. Suspected Covid-19 is the exception to this rule, but please do let AB AfterGlow LLC know asap * ☐

I understand the reservation and cancellation policies at Renew Therapies and consent to my credit card on file being charged if I fail to give the required notice.

CLIENT DECLARATION: I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. I understand that redness and other reactions may occur from facial treatments. If I experience any discomfort during the treatment I will inform the therapist immediately, so that the products/techniques can be adjusted. The treatments I receive here are voluntary and I release AB AfterGlow LLC from liability and assume full responsibility thereof. * ☐ I have read the Client Declaration and agree to release responsibility.

AB AfterGlow LLC occasionally contact clients to follow up on a session and also send booking confirmation and a reminder via email / SMS. AB AfterGlow LLC occasionally send emails regarding company news, updates, special offers etc. You may unsubscribe from these marketing emails at any time. Please confirm you give your permission for AB AfterGlow LLC to: *

- ☐ Contact you about appointment and relevant follow up.
- ☐ Send occasional emails with news, special offers etc.

Signature: _____

Thank you for taking the time to complete this form - I look forward to seeing you soon.

Ashley