

**LA PIELE SPA**  
**Confidential Patient Profile**

Date \_\_\_\_\_  
Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_  
E-Mail \_\_\_\_\_ how do you hear about LA PIELE? \_\_\_\_\_  
Are you pregnant or nursing? \_\_\_\_\_  
Are you allergic to LATEX? \_\_\_apples\_\_\_citrus\_\_\_,grapes,\_\_\_, aspirin,\_\_\_\_\_,  
hydroquinone\_\_\_,mushrooms\_\_\_,nuts\_\_\_,strawberries\_\_\_  
If any other allergies, what? \_\_\_\_\_

Please list any health conditions you have or have had \_\_\_\_\_  
List oral medications including birth control \_\_\_\_\_  
List topical medication if applies \_\_\_\_\_  
Have you ever been treated for a skin condition? \_\_\_\_\_  
If yes, please list condition treated & treatment \_\_\_\_\_  
Do you use sunscreen & how frequently? \_\_\_\_\_  
Any history or currently have \_\_\_eczema\_\_\_dermatitis\_\_\_psoriasis\_\_\_keloid scarring\_\_\_  
Do you get cold sores or fever blisters on lips or face? \_\_\_\_\_  
Do you burn or tan due to sun exposure? \_\_\_\_\_ Wear sunscreen? Please list: \_\_\_\_\_  
Within the last 6 weeks, please check if you have applied the following to your skin or taken orally:  
\_\_\_Retin-A(retinol)\_\_\_Glycolic/Salicylic Acid\_\_\_Skin Lightener\_\_\_Benzoyl Peroxide\_\_\_Accutane\_\_\_Antibiotic  
\_\_\_Differen, or any other prescription topical medication: Please List: \_\_\_\_\_

Have you undergone cosmetic surgery? Botox? Restylane? Please list which & when:

Are you a smoker? \_\_\_What is your alcohol consumption? \_\_\_ Glasses of water/ day? \_\_\_\_\_  
Do you participate in vigorous activity or sports? exercise? \_\_\_\_\_ \*certain peels require no activity for 2 days  
What is your stress level? \_\_\_ Do you consume spicy foods? \_\_\_ Do you go to tanning beds or sunbathe regularly?  
Are you prone to hyper pigmentation? \_\_\_ Keloid scarring \_\_\_\_\_ Anemia \_\_\_  
Please check Y (yes) or N (no): \_\_\_High Blood Pressure\_\_\_Cancer\_\_\_Diabetes\_\_\_Hemophilia\_\_\_Lupus\_\_\_Hepatitis  
\_\_\_Hormonal Imbalances\_\_\_IBS (irritable bowel)\_\_\_Constipation\_\_\_Acid Reflux  
What specific areas do you want to treat? Face\_\_\_Chest\_\_\_Hands\_\_\_Other: \_\_\_\_\_  
What type of cleanser do you use? Soap / Gel/ Milky Does your skin feel TIGHT after you cleanse? \_\_\_\_\_  
Please list all other products used daily:  
\_\_\_\_\_

Please circle, which you feel, describes your skin:

Oily Tight/Dehydrated Combination Dry/Flaky Acne/Blemished Blackheads Whiteheads  
Broken Capillaries Ruddy & Red Sun-damaged Uneven Tone Dull/Devitalized, Lackluster  
Rough Texture Scarring Large Pores Sensitive Highly Allergic

Would you like to start a regular facial program? \_\_\_\_\_ would you like product recommendations? \_\_\_\_\_  
What is your goal of TODAY'S treatment? \_\_\_\_\_ Have you ever had a facial? \_\_\_\_\_  
Please list the changes you would like to see in your skin \_\_\_\_\_

We offer SPRAY TAN, CHEMICAL PEELS, MICRODERMABRASION, FACIALS, WAXING,  
MAKEUP ARTISTRY, BROW SHAPING, HOT TOWEL FOOT TREATMENT,  
ANTI-AGING HAND TREATMENTS, BODY PEELS, BACK FACIALS, MAKEUP LESSONS  
\*Please circle the services you are interested in

would you like to receive promotions & discounts? \_\_\_\_\_ via email or mail? \_\_\_\_\_  
FIND US ON FACEBOOK REFER A FRIEND AND RECEIVE \$10 VOUCHER towards a service

If I experience any pain or discomfort during the session, I will immediately inform the esthetician so that the products and / or technique may be adjusted to my level of comfort. I further understand that facial should not be construed as a substitute for medical examination, diagnosis, or treatment. I understand that estheticians are not qualified to perform, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because certain treatments should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the esthetician updated as to any changes in my medical profile during the session and understand that there shall be no liability on the estheticians part should I fail to do so. I also understand that the Licensed Esthetician reserves the right to refuse to perform treatments on anyone whom he / she deems to have a condition for which facial treatments are contraindicated. I am aware that esthetic services are cosmetic & elective, and take full responsibility if I agree to have a service. I understand that cosmetic services is not a replacement for cosmetic surgery, and multiple treatments may be necessary to achieve the desired effect. I agree to follow the esthetician's pre & post protocol for more advanced skin care treatments, and do acknowledge that if I fail to do so, complications may occur, and results may not be optimal.

Client's Name ( please print) \_\_\_\_\_

Client Signature \_\_\_\_\_

Date \_\_\_\_\_ NAME: \_\_\_\_\_

ESTHETICIAN'S NAME: \_\_\_\_\_

WITNESS: \_\_\_\_\_