

how did you hear about us?

birthday 

phone 

email 

city state zip

address 
apt/unit

name 

skin therapist

powered by
face mapping®



dermalogica®
consultation card

treatment / product record

date	skin therapist	notes
samples		
date	skin therapist	notes
samples		
date	skin therapist	notes
samples		

treatment / product record

date	skin therapist	notes
samples		
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samples		
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samples		

consultation card

Please answer these questions to help us provide the best service for your skin.

your health

- 1 Within the last year, have you had any health problems that have affected or could affect your skin? yes no
If yes, please specify: _____
- 2 List any medications, supplements, vitamins, diuretics, slimming pills, oral contraceptives, Isotretinoin, etc. that you take regularly.
- 3 Do you wear contact lenses? yes no
- 4 Do you have metal implants, a pacemaker or body piercings? yes no
- 5 Do you have any allergies? yes no
If yes, please specify: _____
- 6 Do you have sinus problems? yes no
- 7 Have you ever experienced claustrophobia? yes no

your skin

- 8 What are your specific concerns/challenges with your skin? _____
- 9 What skin care products are you currently using? _____
 soap cleanser toner moisturizer
 masque exfoliant eye products other
- 10 Have you had chemical peels, microdermabrasion or any resurfacing treatments within the last three months? yes no
- 11 Have you been waxed within the last 72 hours? yes no
- 12 Have you used Retin-A, Renova, Adapalene or any other prescription skin products within the last three months? yes no
- 13 Are you currently using any products that contain the following ingredients? yes no
 Glycolic Acid Lactic Acid any exfoliating scrubs
 Other Hydroxy Acids Vitamin A derivatives (i.e., Retinol)
- 14 Please specify if any of the following apply to you:
 pregnant trying to become pregnant lactating menstruating pre-menstrual

This consultation card is used to evaluate your individual skin care needs. We will maintain the confidentiality of this information, and will disclose this information only: (i) to our staff members, (ii) to quality assurance and quality control personnel, (iii) to our product supplier and manufacturer. We will not provide this information to anyone else, except as required by law, and we will not sell this information to anyone. We may, however, contact you with product-related information.

I confirm (to my best knowledge) that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment.

signature	date	signature	date
signature	date	signature	date
signature	date	signature	date

pro power peel consent for treatment

This treatment is designed to resurface the skin. You may experience temporary burning, itching, or stinging. Please inform your professional skin therapist if you experience these sensations.

Your full participation during and after the treatment will determine the outcome. It is important that you strictly adhere to the homecare products and regimen that your professional skin therapist has recommended. It is possible to have a poor reaction or less-than-expected improvement of the skin. No guarantee is made or implied as to the precise results, peeling times or discomfort.

- 1 Have you received a cosmetic light-based procedure such as laser treatment, IPL, etc. within the last 6 weeks? yes no
- 2 Do you have active cold sores? yes no
- 3 Have you received Botox or other injectable procedures within the past week? yes no
- 4 Do you sunbathe or use tanning beds? yes no
- 5 Do you experience redness, itching, or stinging on your skin? yes no

I release and waive any claims against Dermalogica, LLC and _____, their affiliates and subsidiaries, and their respective officers, directors, agents, servants and employees, for any liability, demands, actions and causes of actions whatsoever arising out of or related to any loss, damage or injury that may be sustained by me while participating in the Pro Power Peel treatment, including, but not limited to, those injuries and damages caused by the negligence and or breach of warranty, express or implied, on the part of Dermalogica and/or _____.

I have received Post-Care instructional sheet.

consent signature

date