CLIENT AGREEMENT

Please relax, smile and complete all questions. We are happy to meet you!

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Today's Date: ________________

First and Last Name: ____

Gender: □ Male □ Female □ Other ____________________ □ Prefer not to say

Birthdate: __________________ **Age:** ______

Home Address: ____

City: ________________________ **State:** _____ **Zip Code:** ___________

Phone Number: (_____) ______ - ________

Email Address: ______________________________

To stay in touch with you, please let us know all the ways you would like to hear from us:

□ Email Communication □ Text Message Communication

□ Email Marketing □ Text Message Marketing

We take your Privacy very seriously. Email and Text Message Communication will only be used for content related to your ongoing wellness journey with us, services and/or appointments. Email Marketing and Text Message Marketing will only be used for content related to promoting our services and/or products, sales/discounts, news updates, etc. You are free to change your preferences at any time by reaching out to meghan@beautifulimagesuman.com. By checking any of the boxes above, you are agreeing to receive these communications until you state your desire to change preferences. Thank you!

Emergency Contact's First and Last Name: ___________________________
Emergency Contact's Phone Number: (_____) _______ - ________ Ext. ________

How did you hear about Suman's Facial Sculpting? ____________________________
What do you hope to accomplish with Suman's Facial Sculpting? ____

Skincare Routine

Describe your current skincare routine. Be specific about how often you perform these steps.

Cleanser: _________________________ Serum: ___________________________
Gel: ____________________________ Exfoliant: _________________________
Mask: ___________________________ Day/Night Cream: ____________________
Body Cream: ______________________

Do you have sensitive/reactive skin? Please describe. When do you experience it – never, rarely, after cleansing, often, or all the time?

Do you feel pulling/dryness/itching? Please describe. When do you experience it – never, rarely, after cleansing, often, or all the time?

How would you describe your skin?

□ Oily (shiny skin with visible pores) □ Combination (shiny skin in certain areas, normal and dry in others)

□ Dry (skin that appears thinner and rougher with the possibility of redness and dead skin cells) □ Normal

□ Dehydrated (temporary condition caused by the lack of hydration, pulling and uncomfortable especially after a shower or cleansing skin, generally oily on the side of the nose, the forehead and the chin)

Do you ever get blemishes/blackheads?

□ Never □ Occasionally (when stressed, tired, during period, etc) □ Regularly (blackheads, dilated pores, blemishes)
□ All the time (frequent blemishes, acne)

Describe your expression lines.
- □ No wrinkles
- □ Some fine expression lines
- □ Visible wrinkles
- □ Deep wrinkles

How would you describe your complexion?
- □ Clear, radiant complexion
- □ Dull, lackluster complexion
- □ Some pigment spots

Medical Conditions

Certain conditions may restrict or preclude this treatment. Please indicate if you have any of the following.

Do you have any allergies? If so, what are they? Are you taking any medications for these allergies? How often?

Do you take any medications? If so, which ones? How often?

Do you take any nutritional supplements? If so, which ones? How often?

Do you currently have any of the following conditions? Have you ever had any of the following conditions?

□ Epilepsy □ Pacemaker/Pacemaker Leads □ Multiple sclerosis □ Heart Condition

□ Muscular Condition □ Pregnancy □ Metal IUD □ Collagen Injections

□ Botox Injections □ Cancer □ Skin disorders or skin allergies

□ Inflammation, infection or disease of the skin □ Recent scar tissue

□ Facial metal implants □ Lack of normal skin sensation □ Any circulatory problems

□ Previous cosmetic surgery or procedures *If you are currently pregnant, when is your due date?* ________________________

If you currently have cancer, what kind is it? How long have you had it?

If you have had cancer in the past, what kind was it? When did you have it? How long did you have it?

Any other comments regarding your medical conditions?

Lifestyle choices can significantly improve or slow the results of this procedure. The following information will enable us to best customize a program for you. Please answer as honestly as possible.

Do you, or have you ever, used tobacco? List type(s) and amount. ____
Do you, or have you ever, had alcohol? List type(s) and amount per week. ____
What is your salt intake? Do you add salt to your food? Seldom or frequently? ____
What is your caffeine intake? List type(s) and amount per day. ____
How many hours of sleep do you get per night? ____
How many 8 oz. glasses of water do you drink per day? ____
Have you lost or gained any significant weight in the last twelve months? If so, how much? _________________________________
Are you on a carb restricting diet? If so, how long? ____
What does your diet consist of? Do you eat healthy foods? ____
Do you regularly exercise? If so, do you use weights, cardio or both? ____

Have you ever had professional facial or body services before? If yes, please describe. Which services, and how often?
____

Have you ever had a chemical peel? If so, when? ____
Have you ever had Botox/Injectable Filters? If so, when? ____
Have you ever had IPL Therapy/Treatments? If so, when? ____
Have you ever had skin resurfacing? If so, when? ____
Have you ever had Microdermabrasion? If so, when? ____
Have you ever had surgery? If so, when? ____

Client Signature: ________________________________ Date: __________________________________