LUXE & CO.
AESTHETICS

DERMAFLASH

CONSULTATION FORM

GENERAL INFORMATION

Full name: _____ Date of birth: _____

Address: _____

Phone: _____ Email: _____

What is your gender? ◯ Male ◯ Female ◯ Non-binary ◯ Other

Are you 18 years of age or over? ◯ Yes ◯ No

How did you hear about us? _____

Would you like to be added to our email list for specials and discounts? ◯ Yes ◯ No

MEDICAL HISTORY

Do you have a history of any of the following medical conditions:

- ◯ Hair loss
- ◯ Alopecia
- ◯ Autoimmune disorder
- ◯ Blisters/cold sores
- ◯ Bleeding disorders
- ◯ Skin cancer
- ◯ Chemotherapy/radiation
- ◯ Diabetes
- ◯ Epilepsy
- ◯ Eczema
- ◯ Pigmentation disorders
- ◯ Haemophilia
- ◯ Circulation issues
- ◯ Menopause
- ◯ Heart condition
- ◯ Hepatitis (A,B,C,D)
- ◯ HIV positive
- ◯ Keloid scarring
- ◯ Heart condition
- ◯ Dermatitis
- ◯ Inflamed nerve
- ◯ Skin conditions
- ◯ Thyroid issues
- ◯ Other

If 'Other', please detail: _____

Do you have any known allergies? ◯ Yes ◯ No

If 'Yes', please detail: _____

List any medications you take regularly including vitamins, supplements, aspirin:

_____

List any previous treatments:

_____

Do you ever experience these conditions on your skin? ◯ Flakiness ◯ Tightness ◯ Obvious dryness

Notes: _____

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(continued)

SKIN ASSESSMENT

How do you find your skin?

- Normal
- Combination
- Very Sensitive/rosacea
- Dry
- Sensitive/breakout
- Mature
- Oily
- Acne

Are you currently using the following products or ingredients?

- Glycolic acid
- Hydroxy acid product
- Vitamin A derivatives (i.e retinol)
- Acetic acid
- Renova
- Exfoliating scrubs
- Retin-A

Have you recently received any of the following treatment/s?
(Please specify the date you received your last treatment)

- Microdermabrasion
- Chemical peel
- Lash tint
- Brow tint
- Microneedling
- Botox
- Lip Filler

Please list any concerns you may have: _____

MALE CLIENTS ONLY

What is your shaving system? ◯ Electric ◯ Wet shave

Do you experience irritation while shaving? ◯ Yes ◯ No

Do you experience ingrown hairs? ◯ Yes ◯ No

CLIENT NAME (PRINTED)	CLIENT NAME (SIGNATURE):	DATE:
ESTHETICIAN (PRINTED):	ESTHETICIAN (SIGNATURE):	DATE: