HALO

ESTETIQUE · BY MG

Client Intake & Consent Form

Please complete every section and bring this form to your appointment.

Write in black or blue ink and tick the boxes that apply. Your answers are kept confidential and are used only to keep your treatment safe. Prefer to fill this in online? You can complete the same form when you book at https://haloestetique.com/book.

About you

So we know who we're treating and how to reach you.

First name _____ Last name _____

Date of birth _____ Occupation _____ Phone _____

Email _____

Street address _____

Address line 2 _____

City _____ State _____ ZIP code _____

How did you hear about Halo Estetique?

☐ Facebook/Instagram ☐ Online Search ☐ Referral ☐ Other

If other, please tell us _____

If referred, by who? _____

Emergency contact name _____ Emergency contact number _____

Medical history

This keeps your treatment safe — please answer as fully as you can.

Have you seen a dermatologist in the past year?

☐ Yes ☐ No

If yes, name, contact info and reason for visit _____

Are you currently under the care of a physician or skin care therapist?

☐ Yes ☐ No

If yes, name and contact number _____

Any recent surgery, including plastic surgery?

☐ Yes ☐ No

If yes, please explain _____

Do you have or have you ever had any of the following? *Tick all that apply.*

- ☐ Hormone Imbalance
- ☐ Cancer
- ☐ Skin Disease/Lesions
- ☐ Systemic Disease
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Arthritis
- ☐ Auto-Immune Disorder
- ☐ Asthma
- ☐ Epilepsy/Seizures
- ☐ Frequent Cold Sores
- ☐ Herpes
- ☐ HIV/AIDS
- ☐ Hepatitis
- ☐ Lupus
- ☐ Depression/Anxiety
- ☐ Headaches/Migraines
- ☐ Sunburn
- ☐ Eczema
- ☐ Hemophilia
- ☐ Psoriasis
- ☐ Heart Problems
- ☐ Phlebitis, Blood Clots, Poor Circulation
- ☐ Moles
- ☐ Thyroid Condition
- ☐ Neck or Spinal Injury
- ☐ Any active infection
- ☐ Keloid Scarring
- ☐ Fibromyalgia
- ☐ Head or Neck Pain
- ☐ Other

If other, please explain

Any known allergies? *Tick all that apply.*

- ☐ Aspirin
- ☐ Latex
- ☐ Fruits
- ☐ Lidocane
- ☐ Fragrances/Essential Oils
- ☐ Tree Nuts
- ☐ Dairy
- ☐ Sunscreen
- ☐ Pollen
- ☐ None
- ☐ Other

Any other allergies or sensitivities

List any medications, supplements or herbal remedies you currently take. *Write N/A if none.*

Do you... *Tick all that apply.*

- ☐ Smoke
- ☐ Consume alcohol
- ☐ Use any recreational drugs
- ☐ Consume caffeine
- ☐ Consume water regularly
- ☐ Exercise regularly
- ☐ Follow a restricted diet
- ☐ Have a pacemaker
- ☐ Have any metal implants
- ☐ Wear contact lenses or glasses
- ☐ Frequent tanning booths
- ☐ None

Do you suffer from sinus problems?

☐ Yes ☐ No

Have you ever experienced claustrophobia?

☐ Yes ☐ No

What is your current stress level?

☐ High ☐ Medium ☐ Low

Female clients only

Skip these if they do not apply to you.

Are you pregnant or breastfeeding?

☐ Yes ☐ No

Are you taking birth control or hormone replacement?

☐ Yes ☐ No

Your skin

Tell us about your skin so we can tailor your treatment.

Have you had a facial treatment before?

☐ Yes ☐ No

If yes, when was your last facial or skin treatment?

Are you currently using any products that contain, or taking any of, the following? *Tick all that apply.*

☐ Acne Medication
☐ Prescribed topical cream
☐ Retinol/Vitamin A derivative products
☐ Products containing Hydroquinone or Alpha Hydroxy
☐ AHA's (Glycolic Acid, Lactic Acid, etc.)
☐ BHA (salicylic acid)
☐ None

Have you received any of these skin care treatments? *Tick all that apply.*

☐ Chemical Peel
☐ Microdermabrasion
☐ Dermaplaning
☐ Microneedling
☐ Facial Ultrasound
☐ Laser Hair Removal
☐ Laser Treatments
☐ Waxing
☐ None

Other treatment

If you ticked any of the above, when?

☐ Yes, within the last 7–10 days
☐ Yes, within the last month
☐ Yes, within the last 2–3 months

Have you ever had an adverse reaction after using any skin care product?

☐ Yes ☐ No

If yes, tick all that apply:

☐ Rash ☐ Irritation ☐ Peeling ☐ Sun Sensitivity ☐ Breakout

Have you ever had injectables?

☐ Yes ☐ No

If yes, date of last treatment

What do you consider your skin type?

☐ Normal (no visible blemishes, fine pores, smooth texture)
☐ Oily (enlarged pores, excess oil)
☐ Acne (cystic or nodules)
☐ Dry (dull, visible lines/wrinkles, feels tight)
☐ Aging (dry, very visible deep lines/wrinkles)
☐ Combination (oily and dry patches, oily t-zone, hormonal acne)
☐ Sensitive (reactive to fragrance, often irritated)
☐ Not sure

Do you have hyperpigmentation or hypopigmentation?

☐ Yes ☐ No

Do you have frequent breakouts?

☐ Yes ☐ No

What skin care products do you currently use? *Tick all that apply.*

☐ Soap
☐ Cleanser
☐ Toner
☐ Exfoliator or Scrub
☐ Mask
☐ Moisturizer
☐ Sunscreen
☐ None

Other products

Do you use sunscreen?

☐ Always
☐ Often
☐ Sometimes
☐ Never

What is your daily skin care regimen?

What are your specific concerns at this time regarding your skin?

What is your skin care goal?

Indicate what services or areas you are interested in. *Tick all that apply.*

- ☐ Minimize/Remove Sun Spots / Brown Spots
- ☐ Melasma
- ☐ Wrinkle Reduction
- ☐ Acne Treatment
- ☐ Microneedling
- ☐ Rosacea
- ☐ General Skin Care

Other

Consent

Please read carefully before signing.

By submitting and signing this form, I acknowledge, consent and agree to the following:

I give my permission to receive facials, skin care treatments, eyelash and eyebrow services or waxing services.

I understand that the esthetician does not diagnose illnesses or injuries, or prescribe medications.

I have clearance from my physician to receive facials, skin treatments and waxing services.

I understand the risks associated with facials and waxing include, but are not limited to:

- Superficial bruising or redness
- Short-term muscle soreness
- Exacerbation of undiscovered injury

I acknowledge that my skin might experience temporary irritation, tightness, redness or slight swelling which usually dissipates within 72 hours depending on skin sensitivity.

I acknowledge that if I am allergic to one or more ingredients in the products used, I may experience allergic reactions.

I acknowledge that if I fail to use a minimal sunscreen (SPF45), I am more susceptible to sunburn, skin damage & hyperpigmentation. I should avoid excessive sun exposure.

I acknowledge that this treatment is strictly an elective cosmetic procedure and no medical claims have been expressed or implied.

I acknowledge that I should avoid the use of Retin-A type products, aggressive exfoliation, waxing, and products containing acids that are not part of the recommended take-home regimen for 2–4 weeks following treatment.

I understand the importance of informing my esthetician of all medical conditions and medications I am taking, and to let the esthetician know about any changes to these. I understand that there may be additional risks based on my physical condition.

I understand that it is my responsibility to inform my esthetician of any discomfort I may feel during the session so he/she may adjust accordingly.

I understand that I or the esthetician may terminate the session at any time.

I have been given a chance to ask questions about the session and my questions have been answered.

I consent (to the best of my knowledge) that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment. I give consent for all future treatments.

I, therefore, release Halo Estetique and its staff from all and any liability associated with any injuries and/or current and future conditions resulting from the skincare procedures or products.

Payment

I understand that the balance for my treatment is payable in studio on the day, and that where a deposit is taken at the time of booking it is handled by Square, the studio's payment provider, and my card details are not stored by Halo Estetique.

I have read and agree to the consent above.

Signature _____ Print name _____ Date _____