Katasi Beauty Secrets

FACIAL FORM

CLIENT NAME:

KATASI BEAUTY SECRETS

CONSULTATION FORM

Name: _____

DOB: _____ Age: _____ ◯ Female ◯ Male ◯ NB

Phone: _____ Email: _____

Emergency Contact & Number _____

How did you hear about us? _____

Health & Medical History

Do you have any pre-existing medical conditions or chronic illnesses? Please describe. ◯ No ◯ Yes

_____

Are you currently taking any medications or supplements? ◯ No ◯ Yes

If yes, please describe _____

Have you had any recent surgeries or medical procedures? ◯ No ◯ Yes

If yes, please describe _____

Have you had any allergic reactions to medications or substances in the past? Please describe. ◯ No ◯ Yes

_____

Do you have any known skin allergies or sensitivities? ◯ No ◯ Yes

If yes, please describe _____

Facial & Skincare History

Have you had any previous treatments or procedures for your face or skin? If yes, please describe ◯ No ◯ Yes

_____

What specific concerns or goals do you have for your facial or skincare treatment?

_____

Do you have a history of skin conditions, such as acne, rosacea, or eczema? If yes, please describe. ◯ No ◯ Yes

_____

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Treatment Considerations

Are you a smoker or regularly exposed to secondhand smoke?	◯ No	◯ Yes
Do you frequently expose your face to the sun? Do you use sunscreen on your face?	◯ No	◯ Yes
Do you engage in activities that might stress or damage your skin, such as intense physical activity or outdoor work?	◯ No	◯ Yes
Are you following any specific dietary restrictions or diets that could impact your skin health?	◯ No	◯ Yes
Are you aware of the post-treatment care needed to maintain optimal results?	◯ No	◯ Yes
Do you have any upcoming events or occasions that could affect your availability for treatment or recovery?	◯ No	◯ Yes
Are you willing to follow post-treatment care instructions, including using specific products or avoiding certain activities?	◯ No	◯ Yes
Are you pregnant or breastfeeding?	◯ No	◯ Yes
Have you recently undergone exfoliating or peeling treatments on your face?	◯ No	◯ Yes

By signing below, you agree to the following:

- I have completed this form accurately and truthfully to the best of my knowledge.
- I agree to inform the technician of any changes to the information previously provided.
- I release the technician and their employer from all liability for any harm or losses resulting from falsification or omission of my medical history.

FULL NAME

SIGNATURE

DATE

KATASI BEAUTY SECRETS

CLIENT CONSENT FORM

I hereby consent to and authorize _____ to perform the following procedure: _____

I acknowledge that side effects may occur, and I fully accept this risk. I understand that my Skincare Technician will take every precaution to minimize or eliminate any potential negative reactions. If I experience any complications following my treatment, I agree to consult my Skincare Technician first. I have been given the opportunity to ask questions, and all my concerns have been addressed to my satisfaction.

I confirm that I have read the provided information and have recorded my medical history accurately, including all pertinent details. For future services, I agree to inform my Skincare Technician of any changes to my medical status or the information provided above. I understand that spa services are not medical treatments, and therefore, the Skincare Technician cannot prescribe medical treatments or pharmaceuticals.

I understand and agree that my Skincare Technician may determine it is unsafe for me to continue a treatment due to health-related concerns. In such cases, I may be required to provide a medical release from my physician before resuming the treatment.

I confirm that the information provided above is accurate and complete to the best of my knowledge, and I have not withheld any information that may be relevant to the treatment I am receiving. I accept full responsibility for any side effects that may occur. I consent to the skincare procedure, understanding that it is an elective treatment and no medical claims are implied. I agree to follow the verbal and written aftercare instructions provided to me.

By signing below, I herby acknowledge that I have completely read and fully understand the above agreement.

_____ Technician

_____ Client Name

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TREATMENT RECORD

CLIENT INFORMATION

Name: _____

Phone: _____

SKIN ANALYSIS

Skin type:

☐ Normal ☐ Oily ☐ Dry ☐ Sensitive

☐ Combination

Pores:

☐ Fine ☐ Dilated ☐ Comedones ☐ Milia

Moisture content:

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Elasticity:

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Acne:

☐ No

☐ I ☐ II ☐ III ☐ IV

Skin sensitivity:

☐ Normal ☐ Sensitive ☐ Hyper sensitive

Fine lines (Glogau scale):

☐ I - None ☐ II - Wrinkles in motion

☐ III - Wrinkles at rest ☐ IV - Mostly wrinkles

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TREATMENT RECORD

Known allergies:

_____

Medications:

_____

Previous treatments:

_____

Life style:

☐ Active ☐ Sedentary

NOTES

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Skin Type guide

NORMAL

Balances, clear and not sensitive

SENSITIVE

May burn or itch after using certain cosmetics and skincare porudcts. Can also react with redness

COMBINATION

Drier in some places (mostly cheeks) and oil in others such as T-zone

DRY

Flaky, scaly or rough patches on the face and/or body

OIL

Shiny, greasy looking, most likely to have visible enlarged pores

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CLIENT RECORD

Date	Treatments	Products	Notes	Price

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PHOTOGRAPH AND VIDEO RELEASE FORM

CLIENT INFORMATION

Name: _____

Phone: _____

We kindly request your permission to use these photos for advertising purposes, such as portfolios, online and print ads, and similar materials.
Your consent is essential for us to proceed.
Please review the options below and indicate your preference by circling the appropriate response and providing your signature.
Additionally, we love tagging our clients in photos shared on our Instagram profile!
If you'd like to allow or decline this, please let us know by selecting the corresponding option below.
Thank you!

☐ Yes, feel free to use them

☐ Yes please tag me on Instagram

☐ No, please do not use them

☐ No, please do not tag me

_____ _____

Client Signature Date

KATASI BEAUTY SECRETS

CANCELLATION POLICY

Our goal is to provide quality care in a timely manner. To ensure this, we have implemented an appointment and cancellation policy.

Appointments are in high demand, and canceling early allows another client the opportunity to access timely care. This policy helps us optimize the use of available appointments for all our clients.

When booking your appointment, you will be required to pay a _____ deposit, which will be applied toward the cost of your treatment(s).

Time is specifically reserved for your appointment, procedure, or treatment. If you need to cancel or reschedule, you must notify us at least 24 hours before your appointment to retain your deposit or have it applied to a future booking. If less than 24 hours' notice is provided, the deposit will be forfeited.

If you arrive more than 15 minutes late for your appointment, it will be considered a no-show, and your deposit will be forfeited.

We are happy to answer any questions regarding this cancellation policy.

I have read and fully understand the above Appointment Cancellation Policy and agree to be bound by it's terms. I agree to pay the cancellation fee in the event of a missed appointment.

_____ _____

FULL NAME SIGNATURE