Client Treatment Plan

Date: __________________________

Client name: ________________________________________________________________

I recommend the following professional treatments for you to help achieve the results you desire:

Treatment Type: __________________________________________________________________________________________
Schedule every ____ days/weeks Date scheduled: ____________________________________________________________
__Series recommended of _____ # of treatments

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_________ Cleanser: __________________________ How often: _______________________________________________________________________________________
_________ Exfoliant: __________________________ How often: _______________________________________________________________________________________ 
_________ Serum: ___________________________ How often: ______________________________________________________________________________________ 
_________ Serum: ___________________________ How often: ______________________________________________________________________________________ 
_________ Moisturizer: ______________________ How often: _______________________________________________________________________________________ 
_________ SPF: ______________________________ How often: _______________________________________________________________________________________ 
_________ Repair Tx: _________________________ How often: _______________________________________________________________________________________ 
_________ Mask: ____________________________ How often: _______________________________________________________________________________________ 
_________ Mask: ____________________________ How often: _______________________________________________________________________________________ 
_________ Spot Tx: __________________________ How often: _______________________________________________________________________________________ 
_________ Other: ____________________________ How often: _______________________________________________________________________________________ 

Home Care

If you have any questions about your treatment plan, or when and how to use your home care products, please contact me any time. Your treatment plan may change depending on the rate of progress and changes in your skin.

__(initial) I understand that to achieve maximum benefits and maintain the results from my professional treatments, home care product use as outlined above is essential.

___I commit to my success by pledging to wear sunscreen daily.

Client’s signature ____________________________________________ Esthetician’s signature ______________________________