

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

Treatment Type: _____

Schedule every ____ days/weeks Date scheduled: _____

___ Series recommended of ____ # of treatments

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Schedule every ____ days/weeks Date scheduled: _____

___ Series recommended of ____ # of treatments

Home Care

___ 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: _____

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