# Client Consultation Form Insert Your Logo

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| Name: | | | |
| Address: | | | |
| Postcode | Contact Number: | | |
| Mobile: | Date of Birth: | | |
| Occupation: | | | |
| Nationality/Family Background: | | | |
| How did you hear about us? | | | |
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| Please circle either yes or no where required. | | | |
| Are you pregnant or breastfeeding? YES NO | | | Do you have a regular menstrual cycle? YES NO |
| Please list any medications you are currently taking and what you are taking? | | | Do you have any known allergies? |
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| Please list any current or previous medical conditions. | | | How well do you sleep? How many hours per night? |
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|  | | | Do you exercise? If so what type? YES NO |
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| Have you had any surgical procedures within the last 12 months? If yes, please stipulate. | | | Do you drink alcohol? YES NO  How many drinks per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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|  | | | Do you smoke? YES NO  How many per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| Please list any supplements or natural therapies that you are taking or having previously taken. | | | Do you drink tea/coffee? YES NO  If yes, how many per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Sugar & Milk? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| What products and skin care brand are you currently using at home? | | | Do you wear SPF daily? YES NO |
| Please rate your stress levels  High Moderate Low |
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| Cleanser YES NO  Exfoliator YES NO  Serums YES NO  Masque YES NO  Specialties YES NO  Other | AM  AM  AM  AM  AM | PM  PM  PM  PM  PM |  |
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| Please list previous skin treatments you have had to address your skin. |
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|  | | | What are your skin goals? |
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| Are you currently using any form of vitamin A on your skin? If yes how long for and the strength. | | | Have you had any skin peels in the last 12 months? If yes, please list the brand type/type of peel and results. |
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| Have you had any Intense Pulse Light (IPL), Laser Resurfacing (fractioned or ablative) or Micro-needling in the last 12-18 months? If yes, please stipulate what was being targeted in your skin, the frequency, and results. | | | Have you had filler, anti-wrinkle injections or injectable services? If yes, how long ago? |
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| What are your skin goals? | | | Have you had any cosmetic surgery in the last 12 months? |
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| All information collected is strictly confidential and solely for the benefit of your treatment.  Please sign the consent form prior to treatment by your skin technician. | | | |
| Signature | | | Date |

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| **Home Prescription Details** | |
| **AM** | **PM** |
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| **Treatment Program** | |
| **Treatment 1** | **Treatment 6** |
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| **Treatment 2** | **Treatment 7** |
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| **Treatment 3** | **Treatment 8** |
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| **Treatment 4** | **Treatment 9** |
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| **Treatment 5** | **Treatment 10** |
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