# 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 NOHow 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 levelsHigh Moderate Low |
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| Cleanser YES NOExfoliator YES NOSerums YES NO Masque YES NOSpecialties YES NO Other  | AMAMAMAMAM | PM PMPMPMPM |  |
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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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