



Personal Consultation Form

Client/Patient Name: _____

Address: _____ **Postcode:** _____

Phone Number: _____ **Mobile:** _____

General Health and Skin Health History

How would you best describe your health?

(Please circle) Excellent / Good / Regular / Deficient

Do you: (please ✓ if yes)

- Smoke?
- Exercise regularly?
- Follow a restricted diet?
- Consume caffeine daily?
- Drink water daily? (How many glasses or litres per day?) _____
- Sunbath or use solariums?

Are you on any medication? If so, please specify: _____

Are you taking any specific supplements or vitamins regularly?
If so, please specify: _____

Have you been under a dermatologist's or physician's care within the last year?
 Yes No (please ✓)
If so, please specify: _____

Do you have any pre-existing skin conditions?
If so, please specify: _____

Do you have a history of herpes? If yes have you taken your medication in the past three months? Yes No (please ✓) _____



Are you pregnant or trying? Yes No (please ✓) _____

Are you going through menopause? Yes No (please ✓) _____

Do you use: Retin A® Adpaelene® Renova A® (please ✓)

Do you take Roacutane? (oral acne medication) Yes No (please ✓)

Have you ever suffered from any of the following: (please ✓)

- Epilepsy
- High Blood Pressure
- Cancer
- Tumours
- Skin Lesions

Skin Conditions

Have you ever had chemical peels, IPL, laser or microdermabrasion treatments?

Yes No (please ✓)

If so, please specify and when? _____

How would you categorise your skin? (Please ✓)

Do you burn easily? Yes No

Do you have a tendency to redness or irritation? Yes No

Do you experience skin breakouts or oily shine during the day? Yes No

Do you have skin discolouration or age spots? Yes No

Do you experience discomfort like tightness, dryness or flakiness? Yes No

Does your skin feel rough and lathery thick? Yes No

Are you prone to dehydration, fine lines or wrinkles? Yes No

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Skin Activity and Home Program

What skin care routine do you follow? (Please ✓)

- | | | | |
|-----------------------------------|---------------------------------------|--------------------------------------|--------------------------------|
| <input type="checkbox"/> Soap | <input type="checkbox"/> Sunscreen | <input type="checkbox"/> Serum | <input type="checkbox"/> Other |
| <input type="checkbox"/> Cleanser | <input type="checkbox"/> Exfoliator | <input type="checkbox"/> Moisturiser | |
| <input type="checkbox"/> Toner | <input type="checkbox"/> Eye Products | <input type="checkbox"/> Mask | |

Do you use any products containing ingredients like:

- Glycolic acid / other AHA
- Salicylic acid / other BHA
- Vitamin A Derivatives
- High concentrations of plant extracts
- High concentrations of botanical enzymes
- High concentrations of amino acids

Men only:

Do you experience irritation from shaving?

Yes No (please ✓) if so, please specify: _____

Do you suffer from ingrown hairs? Yes No (please ✓)

What is your current shaving system? _____

Summary

What would be the most important skin concern you would like to treat?

What are your expectations? _____

Clients Signature

Date

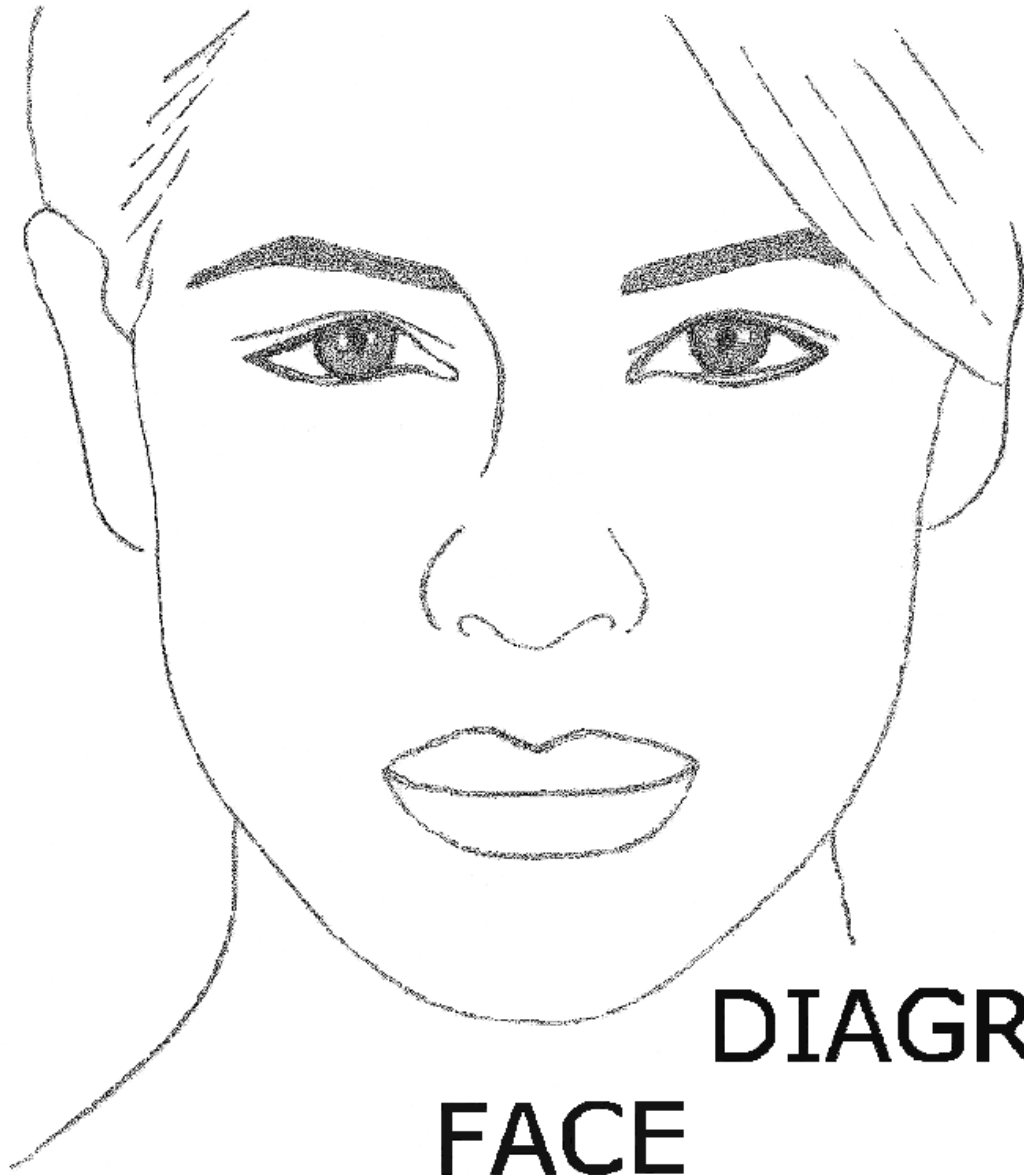
Salon/Clinics Name

Skin Specialist Name

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Please register any skin concerns or pre-existing concerns of the facial tissue



DIAGRAM

FACE

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