Client Consultation Form

This consultation form will assist your therapist in correctly evaluating your needs & choosing the correct treatment for you today. Complete accurately and honest. All information is strictly confidential & remains the property of:

_____

Title: _____ **Name:** _____ **Surname:** _____

Email: _____

Mobile: _____ **Tel no (Day):** _____

Q:Your Health:

Within the last year, have you been under a dermatologist or other physician's care?	YES*	NO
Have you had any health problems in the past or present?		
Are you currently taking any prescribed medicine? (*other than the contraceptive pill*)		
Do you smoke?		
Are you pregnant or do you think you could be pregnant?		
Have you used or currently using retinol / acids or other topical skincare prescribed?		

If you answered yes to any of the above, please specify below:

Q:Your Skin: What would you like to achieve from your facial today? *Please circle those that apply:*

Deep cleansing Hydration Anti-ageing Calming Brightening Extractions Pigmentation Dark Circles Deep exfoliation Target breakouts
Other:

Q:Do you currently have any skin concerns with your face or body? *Yes / No

If yes, please specify below:

Q:What facial skincare are you currently using? *Please circle those that apply:*

Face: Cleanser Toner Moisturiser Exfoliator Mask Eye products Serums **Body:** Moisturiser Exfoliator Oils
Other: