|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Title: | * Mr
 | * Mrs
 | * Ms
 | * Miss
 | * Dr
 | * Other
 |
| Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | D.O.B : \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ |
| Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Contact | * (m) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
|  | * (e) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| **Please tick and provide details if you have or have previously had any of the following or if a statement refers to you:** |
| **HEALTH AND LIFESTYLE**  |
| Are you under medical advice from a health practitioner? | Yes No | *Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
| Are you taking any medications or supplements? | Yes No | *Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
| High / Low Blood pressure | Yes No | AllergiesEg. Nuts, fish | Yes No | *Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
| Diabetes | Yes No | Anaphylactic reactions | Yes No | *Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
| Recurrent headaches | Yes No | Sports / Vehicle accident | Yes No | *Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
| Hepatitis | Yes No | Spinal problems | Yes No | *Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
| Thyroid condition | Yes No | Heart Conditions | Yes No | *Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
| Varicose veins | Yes No | Cancer | Yes No | *Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
| Epilepsy | Yes No | Current bruising/swelling | Yes No | *Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
| Asthma | Yes No | Bowel conditions | Yes No | *Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
| Skin irritation | Yes No | Surgery in last 5 years | Yes No | *Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
| Arthritis | Yes No | Plastic / cosmetic surgery | Yes No | *Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
| HIV | Yes No | Other medical conditions | Yes No | *Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
| Hormonal imbalances | Yes No | Recent sun/sun bed exposure | Yes No | *Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
| Do you smoke? | Yes No | Do you follow a special diet? | Yes No | *Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
| Weekly consumption of the following | * Alcohol \_\_\_\_\_\_\_
 | * Tea/coffee \_\_\_\_\_\_\_\_
 | * Energy drinks \_\_\_\_\_\_\_\_\_\_
 |
| Sleep pattern | * deep
 | * reg
 | * broken
 | * insomnia
 |
| Current stress levels | * low
 | * med
 | * high
 |  |
| Female clients only, please tick if you are | * pregnant \_\_\_\_\_\_\_\_no. of weeks
 | * breastfeeding
 |
| **SKIN CARE TREATMENTS** |
| Have you ever had a skin treatment before? | * Yes
 | Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| What brand of skin care products are you using? | Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you use any of the following for skin care? | * Cleanser
* Exfoliant
 | * Toner
 | * Masks
 | * Moisturiser
 | * Serums
 | * Eye / lip care
 |
| Have you had or are you using?  | * Acid Peel
 | * Retin A
 | * Glycol acid products
 | * Roaccutane or related products
 |
|  | * Botox(TM)
 | * Dermal fillers (eg collagen(TM), restalyne(TM)
 |
| When did you last use any of the above products  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| What 3 things would you like to change about your skin? | 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |