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| 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 | | | | | | Allergies  Eg. 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. \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |