Consultation Card

Name:_____
Date:_____/_____/_____

Clients Address:	
Email:	**Postal Code:**
Home ( )	**Cell ( )**
Date of Birth: ____/____ DAY MONTH	**Work ( )**
Age: Under 21____ 21-30___ 31-40___ 41-50___ 51-60___ 60+ ___	
Emergency Contact:	

Have you had any of these health problems in the past or present?

□ Asthmatic
□ Circulatory Disorder
□ Surgeries _____
□ Hormone Imbalance
□ Blood Pressure High or Low
□ Diabetes
□ Back Problems
□Varicose Veins
□ Thyroid condition
□ Hysterectomy
□ Bruising
□ Infectious Disease
□ Athletes Foot/Verrucae
□ Other _____
If yes please specify.
_____

Pharmaceuticals / Medications

1. _____ 1._____
2. _____ 2._____
3. _____ 3._____
4. _____ 4._____
5. _____ 5._____

Within the last 12 months have you needed to visit a medical practitioner? Yes □ No □
Are you currently taking any pharmaceutical or homeopathic medication? Yes □ No □

Are their any known allergie in your family? (Such as Asthma, Hay Fever etc) Yes □ No □

Do you sufer from Allergies? Yes □ No □
(If yes please specifiy) _____

Do you ever experience claustrophobia? Yes □ No □
Do you or have you ever used any recreational drugs? Yes □ No □
Do you have any piercings/pacemaker or metal implants? Yes □ No □
Do you currently smoke or have you ever smoked? Yes □ No □
Do you follow a restricted diet? Yes □ No □

What is your stress level one a scale of 1 to 4? (1= Low & 4+High)
1 □ 2 □ 3 □ 4 □

Female Clients Only

When is your next period due? _____
If your period have stopped was this natural or surgical? _____
Are you pregnant/or trying to become pregnant? Yes □ No □
Are you taking oral contraception? Yes □ No □
Are you lactating? Yes □ No □
Do you experience skin irritation after shaving or waxing? Yes □ No □
Do you experience hormonal breakouts? Yes □ No □
Where are they located? _____

Male Clients Only

What is your current method of shaving?
_____

Do you experience irritation when shaving? Yes □ No □

Do you suffer from ingrown hairs? Yes □ No □

Occupation & Current Occupational Hazzards

Current _____ How long_____
Did you have a previous occupation? _____ How long did you have this one? _____
Any occupational hazards with work, like Standing, Sitting, Driving, Repetitive Movement?
_____

Current Sleep patterns

What is your current sleep pattern like? (Good, Restless…) _____
How many hours of uninterrupted sleep do you normally get? _____

Diet (Your current eating pattern)

What are your normal times for Breakfast_____ Lunch_____ Dinner_____
How many times in a week do you eat Fast food?_____
How much water do you drink each day? 1-3 cups □ 3-6 cups □ 6+ cups □
How much alcohol do you consume each week? (1 glass of wine = 1 cup) _____
Do you drink caffinated beverages? (Coffee, Tea, Energy drinks, Soft drinks ect.) Yes □ No □
How many daily? ____

Do you use additional Salt or Sugar?
□ Salt_____ 1
□ Sugar _____

Elimination

Do you experience Constipation or Diarrhea? Yes □ No □

Exercise

Do you exercise? Yes □ No □
How often and for how many hours? Daily □ Weekly □ Monthly □ Other _____
What type of activity do you do? _____

Your skin Have you ever had any reaction to the following?

Ointments Yes □ No □
Animals Yes □ No □
Fragrance or perfume Yes □ No □
Sunscreens Yes □ No □
Essential Oils /plants Yes □ No □

Over the counter pills/medication Yes □ No □
Chemicals Yes □ No □

Others _____

What temperature do you cleanse with? Cool □ Warm □ Hot □
What pressure do you prefer in your massage? Light □ Medium □ Firm □
Do you have any skin problems pertaining to your face or body? Yes □ No □
If yes please specify _____
Do you ever experience oily shine during the day? Yes □ No □
Do you ever experience skin breakouts? Yes □ No □
Does your skin ever feel tight or itchy? (Please specify) _____

Exfoliation History

Have you ever had chemical peels, microdermabrasion or any resurfacing treatments? Yes □ No □
If yes, please specify what, when and where. _____
Injectables _____ Dates_____

Current Skin Care

What products are you currently using?

□ Soap
□ Cleasner
□ Toner
□ Moisturizer
□ Scrub or Peel
□ Masque
□ Eye Products
□ Sun screen protction
□ Other _____

Current Body Care

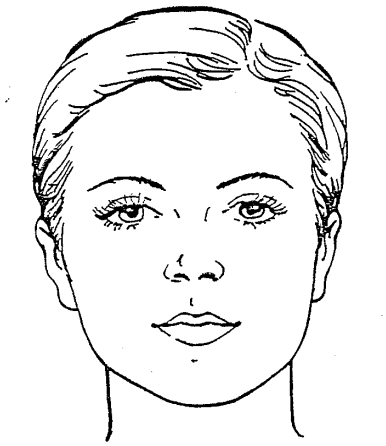
What products are you currently using on your body?

□ Soap
□ Artificial Tanning products
□ Artificial Tanning Machines
□ Moisturizer
□ Exfoliating Scrub
□ Masque
□ Home hair removal products
□ Body Polish
□ Sunscreen protection
□ Other _____

Treatment Goal

What do you expect to achieve from your facial?

_____
_____



Disclaimer. I confirm (to the best of my knowledge) that the answers I have given are correct and that I have not with held any information that may be relevant to my treatment.

Date: / /

Clients Signature: _____ **Therapist Signature**:_____