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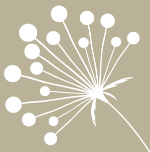
ESSENTIAL therapie



Facial Consultation Form

Please take a moment to fill out the questionnaire below. Your answers will allow your therapist to target your specific conditions and provide you with a truly personalised experience.

Name

Date of Birth

Email

Telephone

General Health

Have you ever experienced any of the following?

- Heart problems ◯
- Skin cancer ◯
- Over / Under active thyroid ◯
- Cold sores ◯
- High / Low blood pressure ◯
- Allergies ◯
- Hormonal problems ◯
- Asthma ◯
- Eye infections ◯
- Diabetes ◯
- Eczema ◯
- Migraine ◯

If yes please specify

Are you currently taking any medication? Yes ◯ No ◯

If yes please specify

Are you currently taking any of the following?

- Birth control pills ◯
- Hormone therapy ◯
- Vitamin Supplements ◯

How much water do you consume daily?

Please indicate the following:

Do you have any metal implants or a pacemaker?	Yes ◯	No ◯
Do you wear contact lenses?	Yes ◯	No ◯
Do you smoke?	Yes ◯	No ◯
Do you consume more than 20 units of alcohol per week?	Yes ◯	No ◯
Do you have sinus problems?	Yes ◯	No ◯
Do you feel that you have a balanced diet?	Yes ◯	No ◯
Do you exercise regularly?	Yes ◯	No ◯
Are you under a lot of stress?	Yes ◯	No ◯

For female clients only

Are you pregnant?	Yes ◯	No ◯
Are you trying to become pregnant?	Yes ◯	No ◯
Are you pre or post menstrual (3 days)?	Yes ◯	No ◯

For male clients only

What is your current shaving system?

Electric ◯ Blade ◯

Do you experience shaving irritation?	Yes ◯	No ◯
Do you suffer from ingrown hairs?	Yes ◯	No ◯

Topical Skin History

Please indicate if you have had any of the following facial procedures in the past 3 months:

- Laser surgery ◯
- Waxing or hair removal ◯
- Chemical peel ◯
- Microdermabrasion ◯
- Sunburn or excessive sun exposure ◯
- Tanning bed exposure ◯
- Other aesthetic treatments (e.g. botox) ◯

Are you using any of the following (or have done in the past 6 months):

- Retinol A/Renova ◯
- Alpha hydroxy acids ◯
- Vitamin C products ◯
- Accutane ◯

Other topical medications

Do you have a tendency towards redness / rashes / hives?	Yes ◯	No ◯
Have you ever had any reactions to products?	Yes ◯	No ◯

Skin Care Routine

Please specify your current brand

Cleanser

Toner

Day Moisturiser

Night Cream

Exfoliant

Eye Cream

Mask

Additional Products

When did you last have a Facial Treatment?