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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	◯
Thrombosis/Phlebitis	◯	Epilepsy	◯
Multiple Sclerosis	◯		

If yes please specify

Are you currently under a physician's care? Yes ◯ No ◯

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	◯	Anti-depressants	◯

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	◯	Botox and Cosmetic Fillers	◯

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?