CONSULTATION CARD

This questionnaire is to allow our therapists to customise your treatment according to your needs. The information is confidential, and will not be passed to a third party. If you do not wish to receive notification of promotions please tick the box. ☐

Client Name: _____ **Date:** _____

Client address: _____ **Post code:** _____

E-mail Address: _____ **Telephone (Day)** _____

Date of Birth: _____ **(Evening)** _____

How did you hear about us? _____ **(Mobile)** _____

MEDICAL HISTORY

Have you been under the Doctors care in the last year? Yes/No Details: _____

Within the last nine months, have you undergone any surgery? Yes/No _____

Please tick any of these health problems you may have had in the past or present:

☐	Diabetes	☐	H.R.T	☐	Hysterectomy	☐	Psoriasis	☐	Sensitive Skin
☐	Thyroid	☐	Liver	☐	Varicose Veins	☐	Epilepsy	☐	Spinal Injury
☐	Cancer	☐	Cold Sores	☐	Metal Pin/Plates	☐	Eczema	☐	Circulatory
☐	Respiratory	☐	Heart	☐	Systemic Disease	☐	Fainting	☐	Kidney

Do you have any known allergies? Yes/No If Yes, Please List _____

Please list any medications you take regularly, please inform us of any change:

FACIALS

Which of the following skin care products are you currently using?

☐ Soap	☐ Cleanser	☐ Toner	☐ Masque
☐ Exfoliator	☐ Eye Products	☐ Moisturiser	

Others: _____

What range of skin care products do you use? _____

Have you ever had chemical peels/laser or dermabrasion? Yes/No

In the last month? Yes/No

MALE CLIENTS

What is your current shaving system? Wet/Dry

Do you experience irritation from shaving? Yes/No

Do you experience ingrown hairs? Yes/No

Skin Analysis

Normal Dry Dehydrated Sensitive Oily Acne

Mature Congested Sallow

MASSAGE AND BODY TREATMENTS

Do you smoke? Yes/No

How much plain water do you consume daily? _____

Do you exercise regularly? Yes/No

Do you follow a special diet at this time? Yes/No

Are you pregnant at this time? Yes/No

What type of massage do you prefer? Soft Medium Firm

Do you suffer from any of the following:

☐ Osteoporosis ☐ Back/Neck/Limbs Pain ☐ Muscular Injuries ☐ Stiff Joint

☐ Recent Broken Bones ☐ Headaches ☐ Recent Scar Tissue

Do you have any specific problems pertaining to your body or general wellbeing

_____

What would you like to achieve from your treatment?

_____

EPILATION AND RED VEIN TREATMENT

EPILATION

On which area do you require treatment?

_____

When did you first notice the unwanted hair?

_____

Have you had previous Epilation?
Yes/No
For How long? _____

Any Scarring or marks?

_____

Previous methods of removal and for how long?

_____

ADDITIONAL MEDICAL CONDITIONS

Do you suffer with any of the following:

Moles ☐ HIV ☐ Hepatitis ☐

Skin Pigmentation ☐

Hormone Imbalance ☐

Does your skin heal well? Yes/No

Are you pregnant? Yes/No

Notes: Needle Size: _____

Reaction: _____

CAPILLARY/MILLIA/SKIN TAG

On which area do you require treatment?

_____

How long has the condition lasted?

_____

Has It got worse?

_____

Have you had previous treatment?

_____

Date of Treatment:

_____

Why did you finish?

_____

Possible causes: Hereditary Dietary Skin Disorder

Pregnancy Injury Medical Allergy Abuse

Dietary Stimulants Bathing Temperature Smoker

Skin Care Routine

Other Please state:

_____

LASH AND BROW TINTING/PERMING AND FALSE TANNING

Have you had false tan applied before? Yes/No
Patch Test: _____ Results: _____ Therapist: _____

Have you previously had your lashes or brows tinted/permed?

Tinted Yes/No Approx Date: _____ **Permed** Yes/No Approx Date: _____

Do you wear contact Lenses? Yes/No Do you suffer from conjunctivitis/Sties? Yes/No

Any other eye conditions? Yes/No

Have you ever reacted to any eye care or make up products? Yes/No

Date of patch test at Beauty Matters……../……. Result:……/…….. Therapist: _____

What colour would you prefer? Brown ☐ Black ☐ Blue/Black ☐

HAND AND FEET

Do you suffer with any of the following nail complaints Dry ☐ Brittle ☐ Weak ☐ Flaky ☐

Are you using any particular product to restore the condition of your nails?

_____

Do you have any of the following:

Veruccae ☐ Bunions ☐ Lifted Nail Plate ☐ Arthritis ☐
Athletes Foot ☐ Corns ☐ In growing Nails ☐ Fungal Nail Infection ☐

WAXING

Do you have sensitive skin? Yes/No Do you suffer with ingrown hairs? Yes/No

Are you taking Roaccutane? Yes/No

What methods have you used before to remove unwanted hair?

_____

NOTE: Due to delicate skin around the eye area, there is a risk that soreness can occur under the eyebrow or between the eyes after having them waxed. It is however quite rare for this to happen, but you should inform your beauty therapist immediately if prolonged redness or stinging of the skin occurs.

THERAPISTS NOTES

I Confirm to the best of my knowledge I have read and understood the above questions and that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment.

Client Signature: _____ **Date:** _____

We will not supply any of this information to third parties and is retained for our use only.