THE GLOW SKIN CLINIC

CLIENT CONSULTATION FORM

In order for your practitioner to hyper-customise your consultation and treatment, we need a comprehensive understanding of your medical history and lifestyle. Please answer the following questions honestly and with as much detail as possible.

CLIENT INFORMATION

Name: ..... Date: .....

Date of birth: ..... Age: ..... ◯ Female ◯ Male ◯ NB

Address: .....

City: ..... Postcode .....

Phone: ..... Email: .....

Emergency contact: .....

How did you hear about us? ◯ Social media ◯ Google ◯ A friend

Would you like to be added to our email list? ◯ Yes ◯ No

MEDICAL HISTORY

Do you have any of the following conditions? If yes, please select them:

- ◯ Acne
- ◯ Autoimmune disorders
- ◯ Asthma
- ◯ Cold sores
- ◯ COPD
- ◯ Cancer
- ◯ Diabetes
- ◯ Dermatitis
- ◯ Eczema
- ◯ Epilepsy
- ◯ Glaucoma
- ◯ Heart disease
- ◯ Rosacea
- ◯ Skin infections
- ◯ High/low blood pressure
- ◯ Hives
- ◯ Psoriasis
- ◯ Hemophilia
- ◯ Hyper/hypo pigmentation
- ◯ Thyroid condition
- ◯ Warts
- ◯ Keloid,hypertrophic scars
- ◯ Lupus
- ◯ Migraines
- ◯ Phlebitis/blood clots

List any medications you take regularly, including vitamins, herbal supplements, aspirin, topicals:

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Any known allergies?

◯ No ◯ Yes .....

Any recent surgery, including plastic surgery?

◯ No ◯ Yes .....

FEMALE CLIENTS

Are you pregnant or trying to become pregnant? ◯ No ◯ Yes

Are you taking birth control pills? ◯ No ◯ Yes

Are you undergoing any hormone replacement therapy? ◯ No ◯ Yes

YOUR LIFESTYLE

What is your occupation: .....

What is your sun exposure?

◯ Never ◯ Light ◯ Moderate ◯ Excessive

Do you use sun protection (sunscreen, hats, protective clothing)? ◯ No ◯ Yes

Do you use tanning beds? ◯ No ◯ Yes

Do you smoke? ◯ No ◯ Yes

Do you drink more than 4 caffeinated beverages a day? ◯ No ◯ Yes

What is your alcohol consumption?

◯ None ◯ Occasionally ◯ Once a week ◯ Few times a week ◯ Daily

YOUR SKIN CONCERNS

- ◯ Acne
- ◯ Age spots
- ◯ Blackheads
- ◯ Broken capillaries
- ◯ Dark circles
- ◯ Dehydrated skin
- ◯ Dry skin
- ◯ Dull skin
- ◯ Eczema
- ◯ Enlarged pores
- ◯ Facial hair
- ◯ Fine lines and wrinkles
- ◯ Hyperpigmentation
- ◯ Ingrown hairs
- ◯ Keratosis pilaris
- ◯ Melasma
- ◯ Milia
- ◯ Oily skin
- ◯ Premature aging
- ◯ Psoriasis
- ◯ Congested skin
- ◯ Rosacea
- ◯ Scars
- ◯ Skin redness
- ◯ Sun damage
- ◯ Thin skin
- ◯ Under-eye puffiness
- ◯ Uneven skin texture
- ◯ Uneven skin tone
- ◯ Whiteheads

YOUR SKIN TYPE

- ◯ Normal
- ◯ Dry
- ◯ Dry/Combination
- ◯ Combination skin
- ◯ Combination/Oily
- ◯ Oily
- ◯ Sensitive

YOUR SKIN CARE ROUTINE

- ◯ Eye makeup remover
- ◯ Cream cleanser
- ◯ Gel cleanser
- ◯ Toner
- ◯ Serum
- ◯ Day cream
- ◯ Night cream
- ◯ AHA/BHAs
- ◯ Retinol
- ◯ Hyaluronic acid
- ◯ Facial oils
- ◯ Masks
- ◯ Exfoliants
- ◯ SPF

Which brands? please list .....

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WHICH OF THESE CLINIC TREATMENTS INTEREST YOU?

UPPER SKIN IMPROVEMENT

- ◯ Skin care
- ◯ IPL
- ◯ Microdermabrasion
- ◯ Facials
- ◯ Dermaplaning

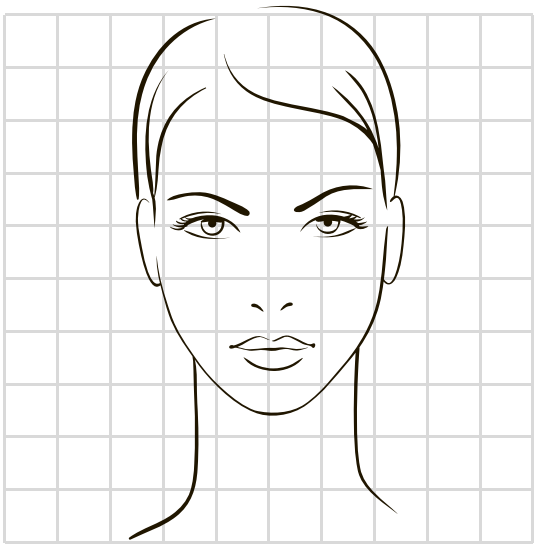
DEEPER SKIN IMPROVEMENT

- ◯ Microneedling
- ◯ Chemical peels
- ◯ LED light therapy
- ◯ Skin injectables
- ◯ Mesotherapy
- ◯ Laser

AFTER THE TREATMENT I WOULD LIKE TO FEEL

- ◯ Fresher
- ◯ Brighter
- ◯ More awake
- ◯ Relaxed
- ◯ More youthful
- ◯ More luminous
- ◯ Happier
- ◯ More confident

PLEASE TICK THE AREA(S) THAT YOU ARE CONCERNED ABOUT?



If you have ticked areas on the face, please explain

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WHAT IS YOUR MONTHLY BUDGET FOR YOUR SKIN

£65-£100 .....

£100-£150 .....

£150 + ...

YOUR SKIN HISTORY

Have you ever had an allergic reaction to any of the following?

- ◯ Alpha hydroxy acids
- ◯ Animals
- ◯ Aspirin
- ◯ Cosmetics
- ◯ Essential oils
- ◯ Food
- ◯ Fragrance
- ◯ Sunscreen
- ◯ Latex
- ◯ Medication
- ◯ Nuts
- ◯ Pollen
- ◯ Skin products
- ◯ Shellfish
- ◯ Other

If you checked any above, please explain .....

Are you currently using products containing any of the following ingredients?

- ◯ Vitamin C
- ◯ Any hydroxy acids (AHAs)
- ◯ Any beta hydroxy acids (BHAs)
- ◯ Vitamin A
- ◯ Retinoids
- ◯ Roaccutane

Any history of previous facials, microdermabrasion, peels or other treatments?

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How does your skin heal? ◯ Fast ◯ Slow ◯ Scars ◯ Pigments

Do you get bruises easily? ◯ No ◯ Yes

Have you ever used or been prescribed any acne medication?

◯ No ◯ Yes: .....

Have you received Botox, Filler, or Collagen injections in the last 6 months?

◯ No ◯ Yes: .....

I have read and completed this questionnaire truthfully. I understand that withholding information or providing inaccurate details about my medical history, allergies, medications, and skincare routines may lead to contraindications or adverse reactions to the treatments I undergo. I agree to inform the technician of any changes in the above information.

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Client Name (printed) *Date*

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Client Name (signature)