FACIAL & SKINCARE
CLIENT CONSULTATION FORM

Please fill out this form on your first appointment.
Your answers will better help us to meet your needs and ensure that you have a happy and satisfying experience.

Appointment Day & Time:

!!"""""##"""""$$ | %%&##

Full Name

!""#$%%

+,-'.'/(%012'3("$ | State / Province

City | Date of birth

Phone | Emergency Contact Phone

Email

6$% No

(Your email address will be used for appointment confirmations, and quarterly newsletters)
If you would like to subscribe to our newsletter and promotions please tick YES or tick NO

Have you ever had a facial treatment before? 6$% No
If yes, when was that?

What are your main concerns?

- !45$
- Acne scarring
- Aging
- Dull/dry skin
- Scars
- Enlarged pores
- Hyperpigmentation
- Dehydrated
- Wrinkles/fine lines
- Deep wrinkles
- Dark eye circles
- Sun damage
- Age spots
- Uneven skin tone
- Blackheads/whiteheads
- Rosacea

What would you like to achieve from your treatment today?

Please check current skin care products you use:

- Facial Scrub
- Cleansing Cream
- Skin Toner/ Astringent
- Soap
- Eye Make-Up Remover
- Day Cream
- Exfoliants
- Eye Cream
- Night Cream
- Mask
- Body Lotion/Cream
- Body Scrub
- Other

How do you find your skin?

- Normal
- Dry
- Oily
- 3(78,510,(5
- Sensitive/Breakout
- !45$
- Very sensitive/Rosacea
- Mature