



CLIENT CONSULTATION

PERSONAL DETAILS

Name _____ Date _____

Address _____

Date of birth _____

Phone number _____

E-mail _____

YOUR HOST SALON/CLINIC IS

WELCOME
TO HEALTHY
SKIN

1: PLEASE ANSWER THE FOLLOWING HEALTH QUESTIONS

Are you prone to any of the following?

	Yes	No
Psoriasis.....	<input type="checkbox"/>	<input type="checkbox"/>
Eczema/Dermatitis.....	<input type="checkbox"/>	<input type="checkbox"/>
Rosacea.....	<input type="checkbox"/>	<input type="checkbox"/>
Keloid scarring.....	<input type="checkbox"/>	<input type="checkbox"/>
Herpes Simplex.....	<input type="checkbox"/>	<input type="checkbox"/>

If you are, where and how long?

Please indicate are you or do you have any of the following

These conditions are contraindicated to the Environ® DF Ionzyme® electrical treatments.

**These require doctors consent*

	Yes	No
Pregnant.....	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>
Porphyria.....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetic*.....	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy*.....	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Irregularities*.....	<input type="checkbox"/>	<input type="checkbox"/>
Metal Plate/Pins.....	<input type="checkbox"/>	<input type="checkbox"/>
Radiotherapy*.....	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy*.....	<input type="checkbox"/>	<input type="checkbox"/>
Moles or Sun Spots Removed*.....	<input type="checkbox"/>	<input type="checkbox"/>
History Thrombosis/Embolism*.....	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory Disorders*.....	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Sclerosis*.....	<input type="checkbox"/>	<input type="checkbox"/>
Any other medical conditions – please specify.....	<input type="checkbox"/>	<input type="checkbox"/>

Any known allergies– please specify.....

Sonophoresis Caution:

Hearing implants.....	<input type="checkbox"/>	<input type="checkbox"/>
Tinnitus.....	<input type="checkbox"/>	<input type="checkbox"/>

Have you been treated with any of the following?

	Yes	No
Hormone Replacement Therapy.....	<input type="checkbox"/>	<input type="checkbox"/>
Bioidentical Hormone Replacement Therapy.....	<input type="checkbox"/>	<input type="checkbox"/>
Contraceptive Pill.....	<input type="checkbox"/>	<input type="checkbox"/>
Topical Corticosteroids.....	<input type="checkbox"/>	<input type="checkbox"/>
Oral Corticosteroids.....	<input type="checkbox"/>	<input type="checkbox"/>
Topical Antibiotics.....	<input type="checkbox"/>	<input type="checkbox"/>
Oral Antibiotics.....	<input type="checkbox"/>	<input type="checkbox"/>
Topical Vitamin A (Retin A).....	<input type="checkbox"/>	<input type="checkbox"/>
Roaccutane.....	<input type="checkbox"/>	<input type="checkbox"/>
Acne Medication <i>(e.g. Benzoyl Peroxide, Azelaic Acid, Alpha Hydroxy Acids)</i>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Thinning Medication <i>(e.g Warfarin)</i>	<input type="checkbox"/>	<input type="checkbox"/>

Any other medication – please specify

If you have answered yes, please indicate when and for how long

Please indicate if you are having or have had any of the following

	Yes	No
CST <i>(Immediately after treatment)</i>	<input type="checkbox"/>	<input type="checkbox"/>
IPL <i>(Immediately after treatment)</i>	<input type="checkbox"/>	<input type="checkbox"/>
Laser Treatments <i>(Wait 2 weeks)</i>	<input type="checkbox"/>	<input type="checkbox"/>
Microdermabrasion <i>(Immediately after treatment)</i>	<input type="checkbox"/>	<input type="checkbox"/>
Electrolysis <i>(Wait 2-3 days)</i>	<input type="checkbox"/>	<input type="checkbox"/>
Facial Waxing.....	<input type="checkbox"/>	<input type="checkbox"/>
Botox <i>(Wait 2 weeks)</i>	<input type="checkbox"/>	<input type="checkbox"/>
Fillers <i>(Consult Practitioner)</i>	<input type="checkbox"/>	<input type="checkbox"/>

Other skincare treatments

If you have answered yes, please indicate when and where

Thank you, your therapist will now take you through the next steps

2: YOUR CONCERNS AND SKIN TYPE

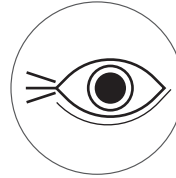
Tell me what are your main concerns?



Lines and wrinkles



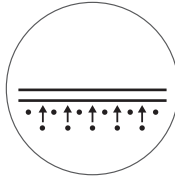
Dark spots



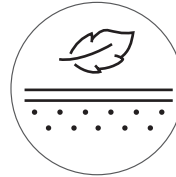
Eye area



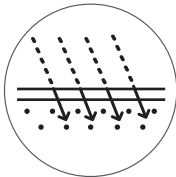
Dryness/dehydration



Firming/lifting



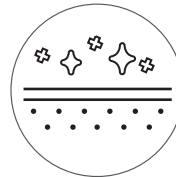
Redness/sensitivity



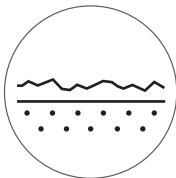
Sun damage



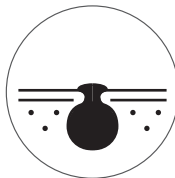
Visible pores



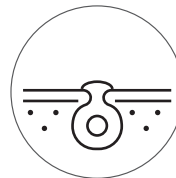
Lack of radiance



Scarring/texture



Oil control



Blemish prone

Please save and email this form to
beauty@theoldforgesalon.co.uk



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20180521/PS - Code: MRK052