



# CLIENT CONSULTATION

## PERSONAL DETAILS

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Name

Date

Address

Date of birth

Phone number

E-mail

YOUR HOST SALON/CLINIC IS

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WELCOME  
TO HEALTHY  
SKIN

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# 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

(e.g. Benzoyl Peroxide, Azelaic Acid, Alpha Hydroxy Acids).....

Blood Thinning Medication (e.g Warfarin).....

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 (Immediately after treatment).....	<input type="checkbox"/>	<input type="checkbox"/>
IPL (Immediately after treatment).....	<input type="checkbox"/>	<input type="checkbox"/>
Laser Treatments (Wait 2 weeks).....	<input type="checkbox"/>	<input type="checkbox"/>
Microdermabrasion (Immediately after treatment).....	<input type="checkbox"/>	<input type="checkbox"/>
Electrolysis (Wait 2-3 days).....	<input type="checkbox"/>	<input type="checkbox"/>
Facial Waxing.....	<input type="checkbox"/>	<input type="checkbox"/>
Botox (Wait 2 weeks).....	<input type="checkbox"/>	<input type="checkbox"/>
Fillers (Consult Practitioner).....	<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

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Tell me what are your main concerns?

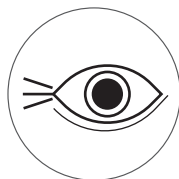
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Lines and wrinkles



Dark spots



Eye area



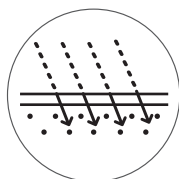
Dryness/dehydration



Firming/lifting



Redness/sensitivity



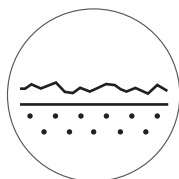
Sun damage



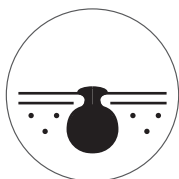
Visible pores



Lack of radiance



Scarring/texture



Oil control



Blemish prone

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Show me where you are noticing this

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Notes:

<hr/> <hr/> <hr/>
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Please take before and after photographs

## 2: YOUR CONCERNS AND SKIN TYPE

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 Tell me which vitamins and supplements you take? Do you take any for your skin?

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Tell me more about your skin care and make-up routine

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Eye Make-Up Remover

Pre-Cleanser

Cleansers & Toners

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Exfoliators/Masks

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Eyes

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Serums

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Moisturisers

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Sun Protection

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Body

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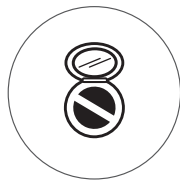


Treatments/Facials

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Foundation

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Eyes

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Cheeks

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Lips

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### 3. YOU AND YOUR LIFESTYLE

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How do your cheeks look and feel?

Dry	Sensitive	Comfortable	Shiny	Oily
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How does your T Zone look and feel?

Dry	Sensitive	Comfortable	Shiny	Oily
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How does your eye area look and feel?

Dark circles	Lines/wrinkles	Puffiness	Firming/lifting	Sensitive
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Describe the environment that your skin lives in

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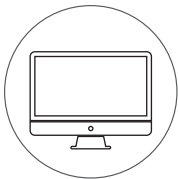
Urban



Frequent Travel



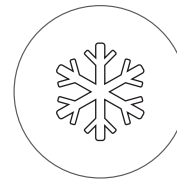
Suburban



Office




Outdoor Activities




Air Conditioning

### 3. YOU AND YOUR LIFESTYLE

 What kind of sun exposure do you get?

Very Low <small>(Incidental exposure from walking)</small>	Low	Moderate	High	Very High <small>(Extended Exposure from being outside)</small>
---------------------------------------------------------------	-----	----------	------	--------------------------------------------------------------------

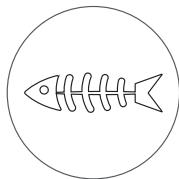
 On average how many hours of sleep do you get a night?

Less than 4hrs	5hrs	6hrs	7hrs	8hrs or more
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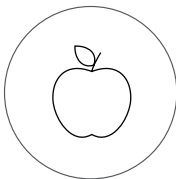
 How would you describe your stress levels?

Very Low	Low	Moderate	High	Very High
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Tell us about your diet & lifestyle



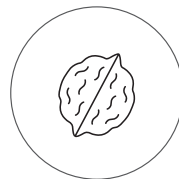
Oily Fish \_\_\_\_\_ per week



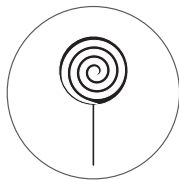
Fruit & Veg \_\_\_\_\_ per day



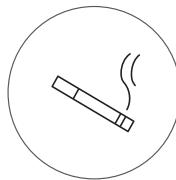
Water Intake \_\_\_\_\_ per day



Nuts & Seeds \_\_\_\_\_ per day



Refined Sugar \_\_\_\_\_ per day



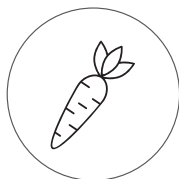
Smoker \_\_\_\_\_ per day



Tea &/or Coffee \_\_\_\_\_ per day



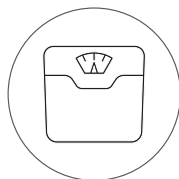
Alcohol \_\_\_\_\_ per week



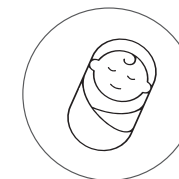
Vegetarian \_\_\_\_\_



Vegan \_\_\_\_\_



Diet \_\_\_\_\_



Breast Feeding \_\_\_\_\_



## 4: LET'S RECAP

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Your main concern is:

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Your skin type is:

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Your skin goals are:

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### **Your Personal Information**

Except for where you have separately granted iiaa permission to store and process your before and after photographs and face scan data, iiaa itself does not store or process your other personal and medical data as captured on this record card - please liaise with the salon direct to understand its arrangements for data security and compliance with data legislation.

**TO THE BEST OF MY KNOWLEDGE THE MEDICAL INFORMATION IS RELEVANT AND FACTUALLY CORRECT.**

Date

Signature

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# 5. YOUR TREATMENT PLAN

## First visit

Date	Treatment
_____	_____
Therapist Name	_____
Products used	_____
_____	_____
_____	_____
_____	_____
_____	_____

## Follow up visit or treatment

**Health Review**

Undertaken by [salon or iiaa employee]: \_\_\_\_\_ Date \_\_\_\_\_

The Client's health data was unchanged since the last visit  The Client's health data changed as described below:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Declaration:** This form including any additional data described above is an accurate reflection of my current health and discloses all relevant medical conditions.

Client Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Health Review**

Undertaken by [salon or iiaa employee]: \_\_\_\_\_ Date \_\_\_\_\_

The Client's health data was unchanged since the last visit  The Client's health data changed as described below:

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\_\_\_\_\_

\_\_\_\_\_

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Client Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Follow up visit or treatment

### Health Review

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Client Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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