# Aesthetic Skin Consultants

**Comprehensive Client Profile**

Name: ____________________________________________________________
Address:___________________________________________________________
_________________________________________________________________
_________________________________________________________________

Home# __________________Work# __________________Mobile#______________

E-mail address: ____________________________________________________

Age: ________________ Date of Birth: ______________ Female/Male:__________

Are you on any medication at
present?:______________________________________________________

Please list any operations or serious illness in the past five (5) years:
_________________________________________________________________
_____________________________________________________________

Do you suffer from any of the following illnesses or diseases:

| | | | |
|---|---|---|---|
| Epilepsy | Cardiac Disease | Photosensitive Med | |
| Lupus | Topical Steroids | Herbal Remedies | |
| Cancer | Bleeding Disorders | Hormonal Med | |
| Keloid Scars | Clotting Disorders | Migraine | |
| Pregnancy | Systemic Diseases | Cold Sores | |
| Hypopigmentation | Hyperpigmentation | Active Tan | |
| Diabetes | Hormonal Imbalance | PolycysticOvaries | |
| Roacutanne | Eczema | Psoraiasis | |
| Skin Disorders | Lumps/Cysts | | |

Have you used/are you using Rx products or medications such as Roaccutane, Birth control pill or hormones? _____________________________________

Have you / are you using Retin A? __________________________________

Do you suffer from depression? ____________________________________

# Aesthetic Skin Consultants

## Client Consultation Form

### What Treatments are you interested in?

**Microdermabrasion: ______________**
**Proliferative Peels: ______________**
**Medium Depth Peels: ______________**
**Skin Rejeuvenation: ______________**
**Vein (facial) Removal: ____________**
**Leg Vein Removal:________________**
**Acne Rocacea: ___________________**
**Acne: ___________________________**
**Hair Removal: ____________________**
**Infra Red Skin Tightening: _________**

Are you taking any Medications at present? – please list and explain.

Have you had any medical/surgical treatment or need for hospitalisation in the past 2 years?

Have you had any other forms of cosmetic enhancement whether it be surgical or non-surgical – including injectable fillers or 'Botox' injections?
______________________________________________________________

**ARE YOU ALLERGIC TO LATEX?** (If yes please elaborate on severity of previous reactions?
______________________________________________________________

Do you have any other allergies/intolerances to foodstuffs, drugs, chemicals, etc?
______________________________________________________________

Do you suffer from Depression? ____________________________________

# Aesthetic Skin Consultants

## Client Consultation Form

**Describe your skin? (circle all that apply to your skin)**

Normal, Oily, Combination, T Zone, Oily/Dry, Freckled, Sun-Damaged, Uneven/Blotchy, Mature, Wrinkled, Saggy, Firm, Large Pores, Small Pores, Acne, Milia, Blackheads, Occassional Breakouts, Acne, Rosacea, Scarred, Melasma, Cystic, Sallow, Pigmented

What problems do you have with your skin?

______________________________________________________________

What products are you using at the moment?

______________________________________________________________

What type of skin do you think you have?

______________________________________________________________

What would you like to see improved with your skin?

______________________________________________________________

What is your daily skin care routine?

______________________________________________________________

Do you use a high quality sunscreen/sunblock daily or regularly?

______________________________________________________________

How much sun exposure have you had in the past? Extreme ___ Moderate____ Rarely____

Do you or have you in the past used sunbeds? Never____ Sometimes______ Regularly______

Do you take any medication? Please list:-

______________________________________________________________

How do you rate your health at the moment?

______________________________________________________________

Do you take any supplements? Please list:-

______________________________________________________________

# Aesthetic Skin Consultants

## Client Consultation Form

Do you Smoke? ______ How many a day? _________

Do you drink alchohol? _______ How many glasses a week? _________
How would you rate your diet/eating habits:- Please list:-
_________________________________________________________________
_________________________________________________________________

Do you eat oily fish regularly? ________________________________________

Do you eat 5 portions or more fruit and vegetables daily? ___________________

How much red meat do you eat? ______________________________________

Roughly how many dairy products do you consume in a week?
_________________________________________________________________

Do you eat any soya products, if so what kinds, how often?
_________________________________________________________________

Have you taken any antibiotics in the past 2 years? How long were you taking them?
_________________________________________________________________

Are you pregnant, breastfeeding or planning a pregnancy in the near future?
_________________________________________________________________

Do you have any hormonal problems and do you suffer from PMT symptoms?
_________________________________________________________________
_________________________________________________________________

Is your energy level good? ____________________________________________

How did you find out about us?
_________________________________________________________________

Please add any more information below if you feel we should know more about you, your lifestyle and your desired results from our treatments?
_________________________________________________________________
_________________________________________________________________

# Aesthetic Skin Consultants

## Client Consultation Form

A digital photo will also be taken prior to your first treatment with Aesthetic Skin Consultants and can be referred to at any time by our practitioners or yourself for comparison results.

All treatments will be handwritten, signed and dated by the individual practitioner during each treatment and you will also be required to sign and date after each treatment.

Please read carefully the following statement and sign if you are willing to continue with treatment with Aesthetic Skin Consultants:

The information I have given is to the best of my knowledge correct. I have not withheld any known medial or surgical state or condition.
I have been advised of the information regarding UV exposure and will inform Aesthetic Skin Consultants Ltd, of any change prior to a treatment.

I understand I will require multiple treatments depending on my response to the treatment to achieve optimal results. Clinical results may vary in different skin types and skin and hair colours and ethnic background and including hormonal changes due to age or medication.
I understand that I have been advised to avoid sun exposure.
I understand that there can be short term side effects and have been made aware of these.

**Client's Signature: ___________________________ Date: ____________**

**Client's Name: _______________________________**

**I understand all the information that has been told to me and I have read all of the above information with regards to contraindications with the treatments I have undertaken whilst attending Aesthetic Skin Consultants Ltd.**

**Therapist Signature: __________________________ Date: ___________**

**Therapists Name: _____________________________**

# Aesthetic Skin Consultants

## Client Consultation Form

**Recommended Treatment Presciption:**

______________________________________________________________________________________________

**Recommended Products:**

______________________________________________________________________________________________

# Aesthetic Skin Consultants

## Client Consultation Form

**CLIENT NAME:** **ADDRESS:**
**D.O.B:**

| Date | Treatment Procedure in detail | # of Shots | Settings and Fluence | Therapist Sign. | Client Sign |
|---|---|---|---|---|---|
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