

Consultation Form

Complete with your client before treatment begins.

CLIENT DETAILS

Name:

Preferred pronouns / title:

He/him, she/her, they, Mr / Mrs / Ms / Miss / none

Address:

Preferred method of communication:

Mobile number:

Email:

Date of birth:

Occupation:

Work style:

Stressful / hazardous / physical / sedentary / shift

Work environment:

Computer, air conditioning, travel, open plan, near window, artificial lighting

How many hours do you normally work?

Emergency contact (name and mobile):

Doctor details:

Medical History & General Health

What is your paediatric history? Natural birth or caesarean? Any childhood illnesses or injuries? Have you had your tonsils removed?

Any major illnesses or immune system illness? How long ago, recovery time, fully recovered?

Any surgery? General anaesthetic? How long ago and recovery time?

Any cosmetic surgery? Where and when? General anaesthetic?

Any cosmetic injections (Botox / fillers)? Where and how long ago?

Medical History & General Health (continued)

Do you or have you suffered from any of the following?

Epilepsy, asthma, high/low blood pressure, cancer, cardiovascular issues, high cholesterol, recurring colds, thyroid problems, diabetes, hormonal

If yes to any above, what medication(s) are you taking for the condition?

Are you or could you be pregnant?

What medication(s) are you currently taking, and what are they for?

Do you have varicose veins or the beginning formation of?

Do you have an impaired lymphatic system as identified by a medical practitioner?

Does your skin mark or bruise easily?

Do you experience facial flushing or flushing of the cheeks? From heat, alcohol, both, or something else?

Are any of your scars keloid?

Are you on any hormone treatment (contraception or HRT)? If yes, for how long?

When was the last time you took antibiotics or antifungal medication?

Any allergies or intolerances (food products, animals, plants/fragrances)? What medication addresses them?

Do you have any allergies that require medical intervention?

Do you carry an EpiPen for any condition?

Health & Lifestyle

What supplements are you currently taking? From a naturopath or medical practitioner? How long and why?

Have you had children? Ages, natural births, any complications?

Are you breastfeeding?

Have you had a hysterectomy? If so, how long ago or at what age?

What are your menstrual cycles like?

Regular / irregular / light / heavy / painful

Any problems related to your menstrual cycle?

Have you been diagnosed with PCOS or endometriosis? Age at diagnosis and treatment?

Have you been through or are you going through menopause? Last cycle? Any effects?

Do you wear contact lenses?

Any metal dental fillings or facial implants?

Do you have superfluous hair? If so, where?

Sleep patterns: bedtime, sleep time, wake time, hours per night, wake during the night, wake feeling refreshed?

What pain medication do you use, and what for?

Are you or were you a smoker/vaper? How often and how many? If stopped, how long ago?

Do you experience slumps during the day? What time, and how do you get through them?

Stress level 1-10 (1 none, 10 extreme). What is the reason for your rating?

Do you have a routine to manage your stress?

Lifestyle, Sun Exposure & Genetic History

What do you do to relax, and how often?

Outside interests or hobbies? How often?

Do you exercise regularly? How often, how long, what types? Strength training? Chlorinated pool swimming?

Do you use a spa pool or sauna? How often?

What other commitments do you have, and how often?

What heating source do you use at home? Cooling system in summer?

SUN EXPOSURE & GENETIC HISTORY

What is your tanning ability?

Pink/burn/peel/no tan; pink/peel/gradual tan; tan/no peel

Maternal genetic history: which countries did your grandparents and great grandparents originate from?

Where were you born, and which countries did you live in during your first 25 years?

Any biological redheads in your family (including facial hair on male relatives)?

How many times have you been sunburnt over your lifetime, and where on the body?

Do you use SPF daily? How long, how often reapplied, what factor?

Do you get regular mole and skin checks? When was your last one?

Nutrition, Diet & Lifestyle

What time of day do you eat your main (largest) meal?

How many meals a day, and what portion size? Big eater or small eater?

Do you snack during the day? How often and what?

How many takeaway or restaurant meals per week or month? What do you usually order?

Do you eat all the food groups?

Fibre, fats/oils, protein, meats, vegetables, legumes, nuts, carbohydrates, grains, fruits, cereal, dairy, dairy alternatives

Who normally prepares meals at home? Do you consider them healthy and balanced?

How often do you consume sugar, bread, pasta, rice?

What dairy products do you consume?

Cheese, butter, milk, cream

Do you follow a fat-free diet? For how long?

Any food intolerances?

Any food allergies?

Do you drink alcohol? What type and how often?

What fluids do you drink each day, and how much?

Water, coffee, black tea, herbal tea, diet drinks, soda, energy drinks, fruit juice, other

Does your weight fluctuate? Please explain.

Are you under the care of a naturopath or qualified nutritionist? For what reason?

Are your bowel movements regular (1-2 x daily)? If not, what frequency?

What are your stools like? (Refer to the Bristol Stool Chart, types 1-7)

Cosmetic & Clinical History

What is your current skin care routine?

What previous clinics or services have you used for treatment? Service, frequency, were expectations met?

Are you currently seeing another skin clinic, dermatologist or doctor for your skin?

Have you ever had microdermabrasion, dermaplaning or chemical peels? Where, how long ago, how often?

How does your skin behave at midday?

Dry, normal, flaky, red, oily on T-zone, feels hot, shiny on T-zone, flushed

How do you currently feel about your skin? What do you love, and what bothers you?

Why the appointment today?

What are your 3 main goals for your skin?

What previous skin care brands have you used, and why did you stop?

Current Products & Makeup

What brand(s) do you currently use, and what are they labelled for? Why did you choose them?

Have you ever had a bad reaction to a product (stinging, burning, wanting it off immediately)? Which product or brand?

How does your skin feel immediately after cleansing? Tight, dry, normal, shiny?

CURRENT SKIN CARE PRODUCTS & REGIME

Product	Brand & skin type labelled for	Frequency
Cleanser		
Toner / tonic / spray		
Serum		
Facial oil		
Moisturiser		
Night cream		
Exfoliants		
Masks		
Sun protection		

MAKEUP USED

Type	Brand & skin type labelled for	Frequency
Primer		
Concealer		
Foundation		
Blusher / contour		
Eye shadow		

Anything Else & Declaration

Is there any other information you would like to share that may be helpful to this consultation?

Declaration: The information I have provided in this form is true and correct to the best of my knowledge.

Client signature

Date

Therapist signature

Date