

Thomasina's



ADVANCED SKINCARE & BEAUTY

CLIENT CONSULTATION

PERSONAL DETAILS

Name

Date

Address

Date of birth

Phone number

E-mail

YOUR HOST SALON/CLINIC IS

Thomasina's Advanced Skincare & Beauty,
52 Patrick Street,
Fermoy,
Co. Cork
P61 VP40



(087) 6783985
www.thomasinas.com

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

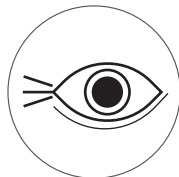
Tell me what are your main concerns?



Lines and wrinkles



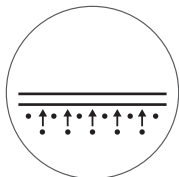
Dark spots



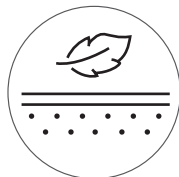
Eye area



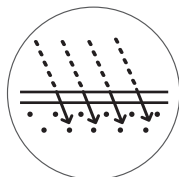
Dryness/dehydration



Firming/lifting



Redness/sensitivity



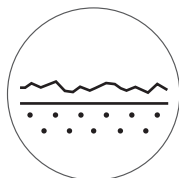
Sun damage



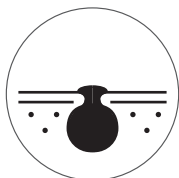
Visible pores



Lack of radiance



Scarring/texture



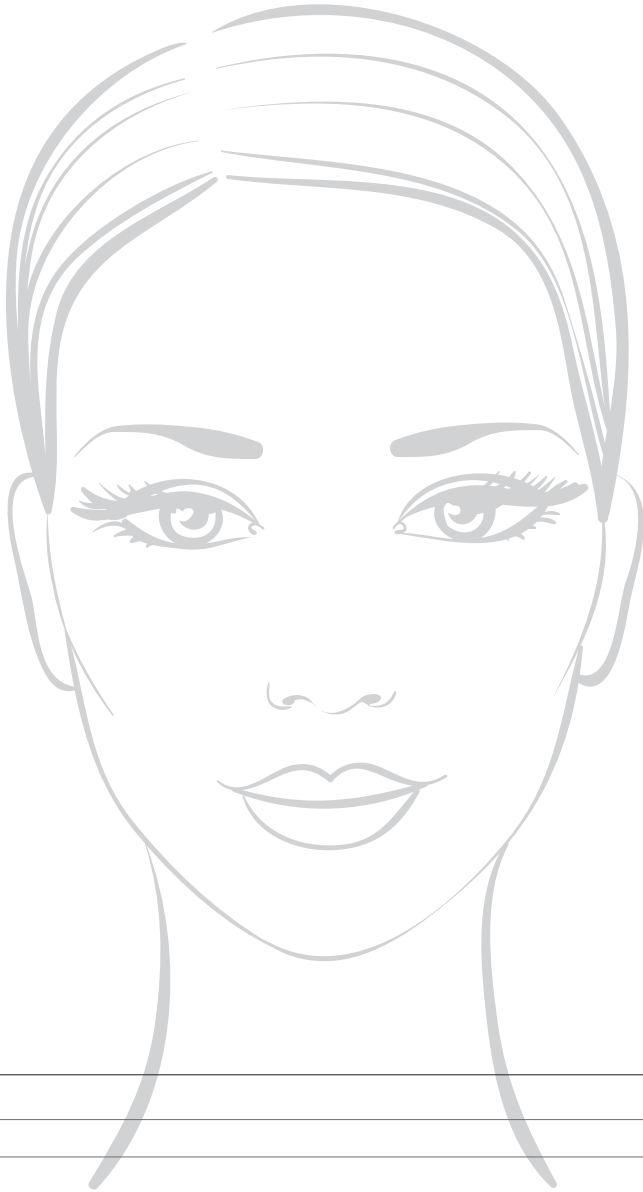
Oil control



Blemish prone



Show me where you are noticing this




Notes:

| |
|-------------------|
| <hr/> <hr/> <hr/> |
|-------------------|

Please take before and after photographs



2: YOUR CONCERNS AND SKIN TYPE

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

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



Eye Make-Up Remover

Pre-Cleanser

Cleansers & Toners



Exfoliators/Masks



Eyes



Serums



Moisturisers



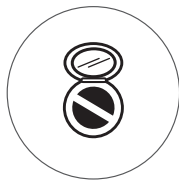
Sun Protection



Body



Treatments/Facials



Foundation



Eyes



Cheeks



Lips



3. YOU AND YOUR LIFESTYLE

How do your cheeks look and feel?

| | | | | |
|-----|-----------|-------------|-------|------|
| Dry | Sensitive | Comfortable | Shiny | Oily |
|-----|-----------|-------------|-------|------|

How does your T Zone look and feel?

| | | | | |
|-----|-----------|-------------|-------|------|
| Dry | Sensitive | Comfortable | Shiny | Oily |
|-----|-----------|-------------|-------|------|

How does your eye area look and feel?

| | | | | |
|--------------|----------------|-----------|-----------------|-----------|
| Dark circles | Lines/wrinkles | Puffiness | Firming/lifting | Sensitive |
|--------------|----------------|-----------|-----------------|-----------|



Describe the environment that your skin lives in



Urban



Frequent Travel



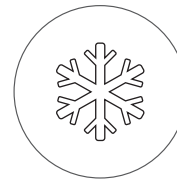
Suburban



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> |
|---|-----|----------|------|--|

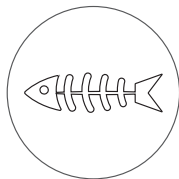
 On average how many hours of sleep do you get a night?

| | | | | |
|----------------|------|------|------|--------------|
| Less than 4hrs | 5hrs | 6hrs | 7hrs | 8hrs or more |
|----------------|------|------|------|--------------|

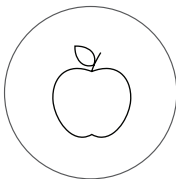
 How would you describe your stress levels?

| | | | | |
|----------|-----|----------|------|-----------|
| Very Low | Low | Moderate | High | Very High |
|----------|-----|----------|------|-----------|

Tell us about your diet & lifestyle



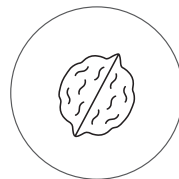
Oily Fish _____ per week



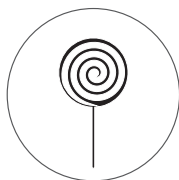
Fruit & Veg _____ per day



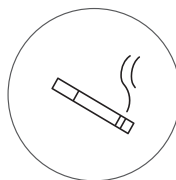
Water Intake _____ per day



Nuts & Seeds _____ per day



Refined Sugar _____ per day



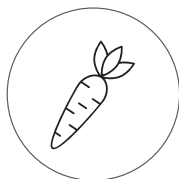
Smoker _____ per day



Tea &/or Coffee _____ per day



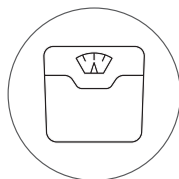
Alcohol _____ per week



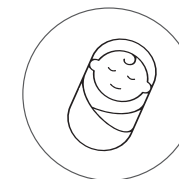
Vegetarian _____



Vegan _____



Diet _____



Breast Feeding _____



4: LET'S RECAP

Your main concern is:

Your skin type is:

Your skin goals are:

Your Personal Information

I am happy to grant Thomasina's Advanced Skincare & Beauty permission to store and process this form, my before and after photographs, and face scan data in relation to my treatments. Please indicate below if you agree. (We are compliant with data legislation).

Yes

No

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

Date

Signature



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

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