

# Welcome to *my salon name*



The information you provide will be used to help your therapist recommend treatments and home care that are suitable for your skin

Client First Name: ..... Client Surname: .....

Street No: ..... Street Name: .....

Suburb: ..... P/Code: ..... Date of Birth: .....

Mobile ☎ ..... Work ☎ : ..... Home ☎ : .....

Email Address: ..... Would you like to sign up for our promotion club Yes No

## **how did you find our salon?**

Walked by	Given a Gift Voucher	Live or Work in the area
Promotional Voucher	Google search	Website
Letterbox drop	Radio	Online Yellow/White Pages

Recommended by another client. If another client, please state their name

## **Your health**

1. Do you or have you had any health problems you think may have contraindications to any treatment? Eg. cancer, asthma, coldsores  
Yes No  
If yes, please provide details: \_\_\_\_\_
2. Are you taking any medication or supplements? Yes No  
If yes, please specify the medication and why it may affect your treatment  
\_\_\_\_\_  
\_\_\_\_\_
3. Are you allergic to aspirin or anything else you think may have contraindications to any treatment? Yes No  
If yes, please provide details: \_\_\_\_\_
4. Do you smoke? Yes No

## **Your skin**

5. What skincare products are you currently using?

Cleanser	Toner	Moisturiser	Scrub
Mask	Eye Cream	Body Scrub	Self Tanners
Serum		Body Lotion/oil	

Current skincare brand/s? \_\_\_\_\_
6. Have you ever had chemical peels, Microdermabrasion or any resurfacing treatment? Yes No  
If yes, please provide details and timing \_\_\_\_\_
7. Do you, or have you used Roaccutane or Vitamin A prescribed by a doctor?  
Yes No  
If yes, last time used? \_\_\_\_\_

8. Have you had dermal fillers/botox in last 2 weeks? Yes No
9. Do you use a solarium? Yes No  
If yes, in the last 24hours? Yes No
10. Do you participate in any rigorous physical activity? Yes No
11. Are you claustrophobic? Yes No

12. Please tick as many areas of concern as applicable

Sensitive skin	Breakout	Lines/Wrinkles
Dry/Tight skin	Open Pores	Lines around eyes
Dehydration	Blackheads	Dark circles under eyes
Oily skin	Milia	Pigmentation

13. Surgery in last 6 months? Yes No
14. If you could change anything about your skin, what would it be? \_\_\_\_\_

## **Female Clients Only**

14. Are you taking oral contraception? Yes No
15. Are you having or due for your period? Yes No
16. Are you taking HRT? Yes No

## **Male Clients Only**

17. Do you experience shaving rash or ingrown hair? Yes No

## **General**

18. What type of massage pressure do you prefer?

Light	Medium	Firm
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**Please sign** —I confirm to the best of my knowledge, that these answers are correct and that I have not withheld any information that may be relevant to my treatment.

**Client Signature:** \_\_\_\_\_