[comfort zone] consultation form

general data

name and surname: contact numbers:

email address: profession:

age: ☐ 18 ☐ 18-25 ☐ 25-35 ☐ 35-45 ☐ 45-65 ☐ 65+

is this your first facial/body treatment? ☐ yes ☐ no

if how frequently do you have facials/body treatments? ☐ 1 x month ☐ 2 x month

☐ 1 x every 3 months ☐ 1 / 2 x year (irregularly)

your face

how do you find your skin? ☐ normal ☐ dry ☐ oily ☐ combination

are you concerned with any of the following?:

☐ spots & pimples ☐ acne ☐ hyper-pigmentation ☐ scarring ☐ sensitivity ☐ dehydration

☐ general dullness ☐ oiliness ☐ dilated pores ☐ sun exposure ☐ under-eye puffiness or dark circles

☐ other, pls specify .....

are you concerned with aging?: ☐ yes ☐ no ☐ aged spots

if yes, what is your immediate concern: ☐ uneven texture ☐ lack of tone and elasticity

☐ fine lines and wrinkles ☐ expression lines

which areas concern you the most in terms of aging?: ☐ eye area ☐ face ☐ décolleté

have you ever experienced any of the following?:

chemical peels ☐ yes ☐ no laser resurfacing ☐ yes ☐ no

roaccutane or retin-A ☐ yes ☐ no botox ☐ yes ☐ no

any other cosmetic surgery? ☐ yes ☐ no if yes please explain .....

do you use any of the following?:

☐ cleanser ☐ soap ☐ toner ☐ exfoliator ☐ mask ☐ eye cream

☐ day moisturizer ☐ night moisturizer ☐ sunscreen ☐ serum / concentrate / booster

other:

.....

what is your primary concern?

.....

what would you like to achieve from your treatment today?

.....

your body

are you concerned with any of the following body conditions?:

☐ weight ☐ loss of tone ☐ muscle tone ☐ elasticity ☐ varicose veins/broken capillaries

☐ heavy legs ☐ dry skin ☐ cellulite ☐ stretch marks ☐ bust area - lack of tone

☐ dry hands ☐ dry feet

do you use any of the following?: ☐ body scrub ☐ body moisturizer ☐ cellulite products ☐ bust products

☐ hand cream ☐ foot cream

what is your primary concern?

.....

what would you like to achieve from your treatment today?

.....

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your health

This information is to ensure we carry out the appropriate treatments for you, taking into consideration any medical conditions which might have treatment contraindications.

please indicate any of the following that apply to you:

☐ pregnancy ☐ menopause ☐ high blood pressure ☐ thyroid - hyper or hypo

☐ heart condition ☐ eczema ☐ asthma ☐ varicose veins

☐ water retention ☐ diabetes ☐ epilepsy ☐ psoriasis

☐ dermatitis ☐ headaches/migraines

any other medical conditions?

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are you taking any medications?

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do you suffer from any allergies?

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do you suffer from claustrophobia?

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your lifestyle

how would you describe your stress levels from 1 - 10 (1=low, 10=high):

how frequently do you exercise: ☐ everyday ☐ 3 x week ☐ 1 x week ☐ irregularly ☐ never

how would you describe your diet: ☐ balanced ☐ on the run ☐ very unbalanced

do you smoke: ☐ yes ☐ no

do you live in a polluted environment: ☐ yes ☐ no

do you drink alcohol: ☐ daily ☐ occasionally ☐ never

Privacy statement
The skincare history and health information you have provided is used to help our therapists recommend skin care treatments and home care products that are suitable for your skin and condition. It is accessible to authorized staff for that purpose only and may be accessed by you at any time.

your signature:

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print name:

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therapist's signature:

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print name:

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date:
