AFTERGLOW

Afterglow Client Consultation

client name _____
first last

client address _____ apt/unit _____

city _____ state _____ zip _____

e-mail address _____ @ _____

telephone: home _____ cell _____

age _____ birth date _____

your health

Have you been under a dermatologist or other physician's care? [ ] yes [ ] no
Within the last nine months, have you undergone any surgery? [ ] yes [ ] no
If yes, please specify _____
Have you had any health problems in the past or present? [ ] yes [ ] no
If yes, please specify _____
List any medications, supplements, vitamins, diuretics, slimming tablets etc. that you take regularly.
_____
Do you smoke? [ ] yes [ ] no
Do you exercise regularly? [ ] yes [ ] no
Do you follow a restricted diet? [ ] yes [ ] no
Rate your level of stress on a scale of 1 to 4 (1 = low stress, 4 = high stress) _____

your skin

Do you have any special skin problems pertaining to your face or body?
If yes, please specify _____
What skin care products are you currently using?
face: [ ] soap [ ] cleanser [ ] toner [ ] moisturiser [ ] masque [ ] exfoliator [ ] eye products
body: [ ] soap [ ] shower gel [ ] scrubs [ ] oil [ ] body moisturiser [ ] depilatory products [ ] self tanners
Have you ever had chemical peels, laser, microdermabrasion or any resurfacing treatments? [ ] yes [ ] no
in the last month? [ ] yes [ ] no
Do you use Accutane, Retin A, Renova, Adapalene or any other prescription skin products? [ ] yes [ ] no
in the last 3 months? [ ] yes [ ] no
Are you currently using any products that contain the following ingredients?
[ ] lglycolic acid [ ] lactic acid [ ] any exfoliating scrubs [ ] any hydroxy acid product [ ] vitamin A derivatives (i.e. retinol)
How much plain water do you consume daily? _____
How many alcoholic beverages do you consume weekly? _____
Do you ever experience these conditions on your skin? [ ] flakiness [ ] tightness [ ] obvious dryness
What spf sunscreen do you use on your face? _____ body? _____
Do you sunbathe or use tanning beds? [ ] yes [ ] no
Do you burn easily in moderate sunlight? [ ] yes [ ] no
Do you blush easily when nervous? [ ] yes [ ] no
Do you have a tendency to redness? [ ] yes [ ] no
Do you suffer from sinus problems? [ ] yes [ ] no
Do you ever experience oily shine during the day? [ ] yes [ ] no
Do you ever experience skin breakouts? [ ] yes [ ] no
Do you drink more than 4 caffeinated beverages daily? (coffee, tea, soft drinks) [ ] yes [ ] no
Do you ever experience a burning, itching sensation on your skin? [ ] yes [ ] no
Have you ever had a reaction to any of the following?
cosmetics [ ] medicine [ ] iodine [ ] pollen [ ] food [ ] hydroxy acids [ ] animals [ ] fragrance [ ] sunscreens
[ ] other _____

female clients only

Are you taking oral contraception? [ ] yes [ ] no
Are you pregnant and seeing changes in your skin? [ ] yes [ ] no
If yes, what changes are you experiencing? _____

male clients only

What is your current shaving system? [ ] electric [ ] wet shave
Do you experience irritation from shaving? [ ] yes [ ] no
Do you experience ingrown hairs? [ ] yes [ ] no

What are your skin care goals?

_____

_____