

CONFIDENTIAL CONSULTATION

NAME _____ DATE _____
LAST MIDDLE FIRST
 ADDRESS _____ BIRTHDAY _____
 CITY _____ (STATE) _____ (ZIP) _____ REFERRED BY _____
 PHONE _____ THERAPIST _____
 EMAIL _____

FACIAL ANALYSIS

* For an effective personalized treatment, please be as accurate as possible.

1. Skin Type

- Normal Dry Sensitive Combination Oily
 Sensitive/Breakout Very Sensitive/Rosacea
 Acne Mature

2. What are your present skincare concerns?

- Please check all that apply
 Acne Lesions (cysts) Papules (inflamed) Blackheads
 Acne Scars Pustules (inflamed) Whiteheads
 Dilated Capillaries Ingrown Hairs Enlarged Pores
 Hyperpigmentation (brown spots from sun, scars, hormonal)

Eye Area

- Crows Feet/Wrinkles Puffiness
 Lack of Elasticity Dark Shadows

Mouth Area

- Wrinkles Nasolabial Folds Hyperpigmentation

Check Area

- Loss of Elasticity Cross Wrinkling (sun damage)
 Hyperpigmentation Uneven Texture
 Dilated Pores Visible Capillaries

Neck & Décolleté Area

- Wrinkles Lack of Elasticity
 Severe Sun Damage Hyperpigmentation

4. How often do you receive a facial?

- Regularly Seldom Never

5. Have you recently received any of the following spa services?

- Microdermabrasion Date _____
 Enzyme Peels Date _____
 Acid Peels Date _____
 Waxing Services Date _____

6. Have you received any of the following medical or surgical procedures?

- Rhytidectomy (Face lift) Date _____
 Rhinoplasty (Nose) Date _____
 Blepharoplasty (Eye lift) Date _____
 Laser Resurfacing Date _____
 Dermabrasion Date _____
 Medical Acid Peels Date _____
 Collagen Injections Date _____
 Restylane Injections Date _____
 Botox® Injections Date _____
 Other _____ Date _____

7. Do you use any of the following?

- Eye Make-Up Remover Brand _____
 Cleanser Brand _____
 Toner Brand _____
 Moisturizer Brand _____
 Exfoliator Brand _____
 Mask Brand _____
 Make-up Brand _____
 Sunscreen Brand _____

8. If you could improve one thing about your skin, what would it be?

BODY ANALYSIS

9. What are your present concerns?

Please check all that apply

Dry and/or Flaky Skin

- Arms Elbows Chest Back
 Legs Knees Feet

Oily Skin and/or Breakout

- Back Chest

Loss of Elasticity & Firmness

- Breasts Inner Arms Mid Torso
 Buttocks Inner Thighs

Cellulite

- Back of Arms Stomach Buttocks Thighs

10. List all areas of muscle tension _____

11. List all areas of injuries including breaks and sprains, muscle adhesions, swelling, cuts and bruises, metal plates if any.

12. Have you received any of the following surgical procedures?

- Breast Augmentation Liposuction
 Breast Reduction Tummy Tuck

13. Do you use any of the following products?

- Body Scrub Brand _____
 Body Wash/Soap Brand _____
 Body Moisturizer Brand _____
 Body Firming Cream Brand _____
 Bath Salt Brand _____

14. How often do you receive body treatments?

- Regularly Seldom Never

15. How often do you receive a massage?

- Regularly Seldom Never

16. What massage pressure do you prefer?

- Light Medium Firm

17. If you could improve one thing about your body, what would it be?

