KAW Client Consultation Form

Client name: _____

Address: _____

_____ State: _____ Postcode: _____

General Health

What brings you to the salon today? _____

How would you best describe your health? **O** Excellent **O** Good **O** Deficient

How would you describe your stress levels from 1-10? _____

Do you get 8 or more hrs sleep a night? _____

Are you a shift worker? _____

Tell me about your diet. Does it contain a balance of different food groups and what generally does your diet consist of in the following categories:

Vegetables: _____

Protein: _____

Fruit: _____

Nuts: _____

Diary: _____

Wheat: _____

Do you eat 3 meals a day with snacks in between? _____

Is your water consumption tap or filtered? _____

Do you consume alcohol? If yes what type and how many per week? _____

Do you drink carbonated drinks? _____

Do you follow a restricted diet? _____

Do you do any exercise? If yes what type and how often? _____

Do you consume caffeine? If yes what type and how much per day?

_____

Do you smoke? _____

Do you have allergies or allergic to anything? _____

Are you currently under physician's care? (Doctor, Naturopath etc..) _____

Do you suffer from any of the following?

O Epilepsy **O** High/low Blood Pressure **O** Skin Cancer **O** Cancer **O** Skin Lesions

O Diabetes **O** Cold Sores **O** Haemophilia **O** HIV **O** Hepatitis

Do you suffer from any Auto-Immune Conditions? _____

Do you suffer from a Thyroid condition? _____

Any other conditions not listed? _____

Are you currently on or have taken the following medications or supplements in the past 6 months? If yes please specify:

Antibiotic? _____

Roaccutane/Accutane/Isotane? _____

Prescription Vitamin A (Retin A, Renova, Stieva-A, Retrieve)? _____

Topical creams for acne? _____

Any cortisone creams? _____

Hydroquinone or any other skin bleaching agents? _____

Warfarin or any other blood thinning medications? _____

Contraceptive Pill? _____

Aspirin? _____

Pain Medication? _____

Any other prescribed medications?_____

Essential oils? _____

Pre or Probiotics? _____

Herbal Supplements? _____

Are you currently Pregnant or breastfeeding? _____

Have you had any of the following treatments in the last 6 months?

IPL Facial Rejuvenation/Hair Removal? _____

Laser Resurfacing? _____

LED Therapy? _____

Skin Needling? _____

Microdermabrasion? _____

Chemical Peel? (including fruit acids, AHA, Glycolic, lactic, BHA, jessner, retinol) _____

Botox/Dysport? _____

Dermal Filler? _____

Cosmetic/Plastic Surgery? _____

Electrolysis/Diathermy? _____

Facial/Body waxing? _____

Cosmetic Tattooing? _____

Sunbathing/Solarium? _____

Tell me about your homecare products and regime?

Do you have a daily skincare/weekly regime? _____

Do you cleanse morning and night? _____

What do you use to remove cleanser and Make-up? _____

How often do you exfoliate? _____

Which of the following products and brands do you use?

Cleanser? _____

Moisturiser? _____

Toner? _____

Serums? _____

Mask? _____

Eye Cream? _____

Retinol/Vitamin A? _____

Sunscreen? _____

Vitamin C? _____

Facial Oils? _____

Do any of your products have AHA's, BHA, Benzoyl Peroxide, Hydroquinone in them?

_____

Please list what body products you are currently using?

_____

What hair care products do you use? _____

Do you suffer from dandruff or seborrheic dermatitis? _____

Do you regularly Spray Tan or use Fake Tan? _____

Do you suffer from any other following?

Acne? _____

Pigmentation? _____

Dermal Filler? _____

Cosmetic/Plastic Surgery? _____

Electrolysis/Diathermy? _____

Facial/Body waxing? _____

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Diagnoses and Treatment Plan

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SKIN PRESCRIPTION

Cleanser: _____

Hydrator: _____

Exfoliant: _____

Serum: _____

O-Biotics: _____

Eye cream: _____

Mask: _____

Home Roller: _____

Sun Protection: _____

Foundation: _____

INNER HEALTH SUPPORT

Vita-Sol: _____

Miss Vitality: _____

OTHER

_____