



Advanced SkinCARE
BY ANNA-GLADYS

CONSULTATION CARD

YOUR INFORMATION

Name and Surname:

Address:

City: Code:

Telephone Number: ☐ Email Address:

Birthday: Where did you hear about us?

Would you like to receive marketing communication from us? (Tick box) ☐ Y ☐ N SMS ☐ Email ☐

YOUR HEALTH

1. Within the last year, have you had any health problems that have affected or could affect your skin?
☐ Y ☐ N If yes, specify:

2. List any medications, supplements, vitamins, diuretics, slimming pills, oral contraceptives, Isotretinoin, etc. that you take regularly.

3. Do you wear contact lenses? ☐ Y ☐ N

4. Do you have metal implants, a pacemaker or body piercings? ☐ Y ☐ N

5. Do you have any allergies? If yes, specify. ☐ Y ☐ N

6. Do you have sinus problems? ☐ Y ☐ N

7. Do you blush easily? ☐ Y ☐ N

8. How long does the skin stay red after you have blushed?

YOUR SKIN

9. What are your specific concerns/ challenges with your skin?

10. What skin care products are you currently using?
Soap ☐ Masque ☐ Toner ☐ Eye Products ☐
Cleanser ☐ Exfoliant ☐ Moisturizer ☐ Other ☐

11. Have you had chemical peels, microdermabrasion or any resurfacing treatments within the last three months? ☐ Y ☐ N

12. Have you been waxed within the last 72 hours? ☐ Y ☐ N

13. Have you used Retin-A, Renova, Adapalene or any other prescription skin products within the last three months? ☐ Y ☐ N

14. Are you currently using any products that contain the following ingredients?
Glycolic Acid ☐ Other Hydroxy Acids ☐ Lactic Acid ☐ Vitamin A Derivatives (Retinol) ☐ Any Exfoliating Scrubs ☐

15. Please specify if any of the following apply to you:
Pregnant ☐ Trying to become pregnant ☐ Lactating ☐ Menstruating ☐ Pre-menstrual ☐

This consultation card is used to evaluate your individual skin care needs. We will maintain the confidentiality of this information, and will disclose this information only (i) to our staff members, (ii) to quality insurance and quality control personnel, (iii) to our product supplier and manufacturer. We will not provide this information to anyone else, except as required by law, and we will not sell this information to anyone. We may however contact you with product-related information.

I confirm to the best of my knowledge that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment.

SIGNATURE

DATE (YYYY-MM-DD)

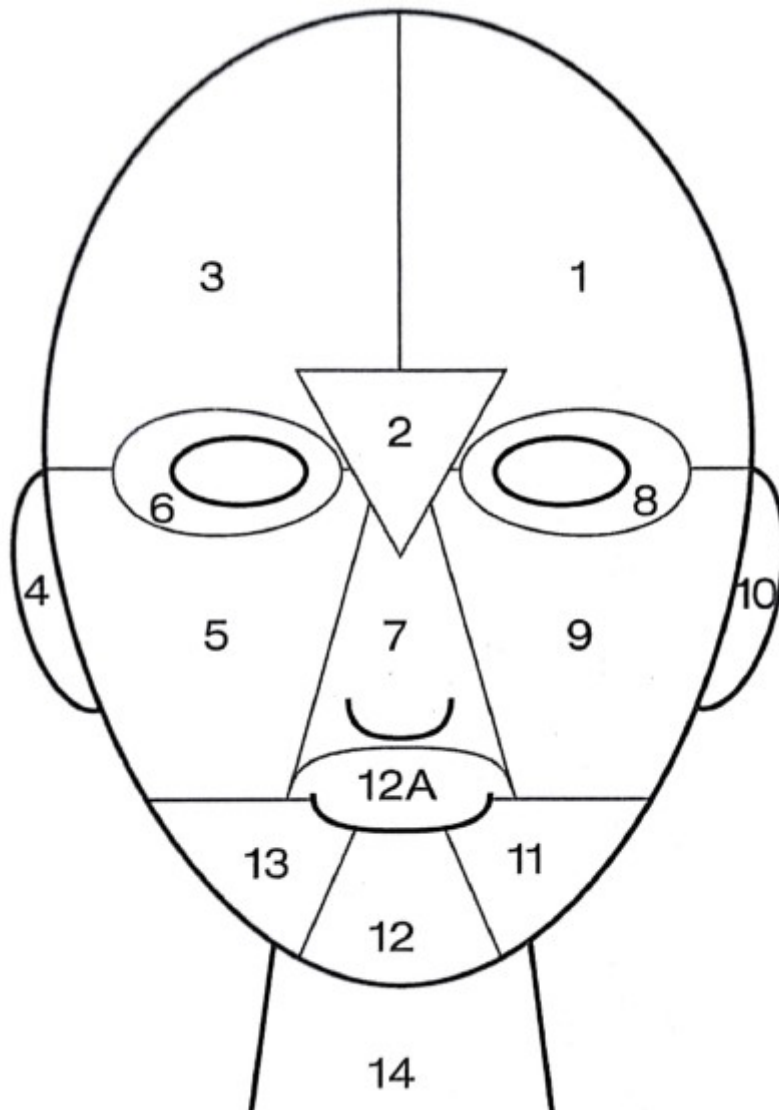
SKINCARE HOURS

Monday: Only Laser hair removal | Tuesday & Friday: 09:00-12:15 | Wednesday & Thursday: 09:00-13:00
After hours on request @ 10% extra



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THERAPIST NOTES



b = breakout activity

c = comedones

d = dilated capillaries

dh = dehydration

m = milia

p = pigmentation

fl = fine lines

dl = deep lines

s = sensitivity / redness
