



sallydurant
aesthetic education & training

CLIENT REF

DATE OF
CONSULTATION

The CIBTAC / SALLY DURANT
Level 4 Qualifications in Advanced Skin
Studies and Aesthetic Practice

CLIENT CONSULTATION FORM

Client Name

Practitioner Name

Client First Name	Last Name
Title	Date of Birth
Home Tel No	Mobile No
Email Address	
Address	
Emergency Contact Name & Mobile No	
Doctor's Name & Address	
Doctor's Tel No	
Personal Status	Do you wear contact lenses?
Number & Age of Children	
<p>Which aesthetic facial treatments have you received in the past? How long ago and were you happy with the treatment?</p> <p><input type="radio"/> Chemical peel _____</p> <p><input type="radio"/> Micro- Needling _____</p> <p><input type="radio"/> Laser / IPL Hair Removal _____</p> <p><input type="radio"/> Laser IPL Skin Rejuvenation _____</p> <p><input type="radio"/> Radio Frequency _____</p> <p><input type="radio"/> Blemish Removal _____</p> <p><input type="radio"/> Botulinum Toxin _____</p> <p><input type="radio"/> Dermal Fillers _____</p> <p><input type="radio"/> PDO Threads _____</p> <p><input type="radio"/> Other – please state _____</p>	
<p>Which of the following skin care products do you use regularly? Give Details</p> <p><input type="radio"/> A Skin Cleanser _____</p> <p><input type="radio"/> Exfoliant _____</p> <p><input type="radio"/> Antioxidant Serum _____</p> <p><input type="radio"/> Hydration Serum _____</p> <p><input type="radio"/> Moisturising Cream _____</p> <p><input type="radio"/> Retinol _____</p> <p><input type="radio"/> Condition Specific Products _____</p> <p><input type="radio"/> Eye Treatment Product _____</p> <p><input type="radio"/> SPF (Specify level) _____</p> <p><input type="radio"/> UVA Sunscreen _____</p> <p><input type="radio"/> Other – please state _____</p>	
What are your main skin concerns?	

The following questions will help us to determine the various influences on your skin health. It is important to the success of your treatment programme to give accurate answers wherever possible
PLEASE INITIAL AND DATE ANY AMENDMENTS TO THIS INFORMATION

What is your occupation?

Do you work in a centrally heated or air conditioned environment?

Are you city based?

Do you work or spend your leisure time mainly outdoors?

Do you smoke cigarettes? How many per day?

What is your average weekly alcohol consumption?

How much water do you drink per day?

How many teas or coffees per day?

What is your stress level on a scale of 1 – 5?
(5 = high)

How many hours sleep per night do you have on average?

Briefly outline your history and current practices of sun exposure

Do you currently use sunbeds? How often?

Have you ever had skin cancer?

Your Diet

Do you have a specifically restricted diet? Give details
(Eg vegetarian / vegan / calorie controlled / low fat etc)

Have you recently lost or gained weight?

Do you have any dietary intolerances or allergies?

How many portions of Protein do you eat per day?

How many portions of complex carbohydrate (wholegrains and starches) do you eat per day?

How many portions of Simple Carbohydrate (sugars) do you eat per day?

How many portions of fruit / vegetable do you eat per day?

How many portions of fats and oils do you eat per day and what type?

How many portions of fats and oils do you eat per day and what type?

How many portions of dairy produce do you eat per day?

Do you take any supplement? Please specify

Do you suffer from any digestive problems such as IBS or constipation?

What is your exercise regime?

Do you get fresh air every day?

MEDICAL HISTORY FORM

<p>Answer the following questions with a YES OR NO IN EACH CASE and give further details where required. PLEASE INITIAL AND DATE ANY AMENDMENTS TO THIS INFORMATION</p>					
Are you or might you be pregnant?		Are you trying to become pregnant?			
Are you breast feeding?		When is your next menstrual period due?			
Are you currently feeling well?					
Have you had any issues of ill health, even the most minor , in the last 4 weeks?					
Give details					
Are you currently receiving any medical treatment?					
Are you suffering from, or have you ever been diagnosed with any of the following conditions?					
CONDITION	✓	X	CONDITION	✓	X
Diabetes?			High / low blood pressure?		
Epilepsy?			Heart disease/ heart condition?		
Anaphylaxis ?			Hay fever?		
Hepatitis / HIV?			Rheumatoid Arthritis?		
Lupus?			Haemophilia?		
Psoriasis?			Eczema?		
Anaemia?			Alopecia?		
Cancer?			What type and how long ago?		
Polycystic ovarian Syndrome?			Keloid or hypertrophic scarring?		
Anxiety or Depression?			Mental health issues?		
Thyroid problems?			Asthma / lung disease?		
Fainting / dizziness/ vertigo?			Kidney/ liver problems?		
Digestive disorders or diseases?			Neural disease or disorder		
Do you have ,or have you previously had , any other medical condition not already mentioned here.. Please give details.					
Have you received any chemotherapy or radiotherapy in the last 12 months?					
Have you had any surgery or physical injury in the last 12 months ?					
Have you previously experienced any adverse skin reaction to any skin treatment or product? Give details					
Have you noticed any blemishes or localised changes to your skin recently?					

MEDICATIONS

Answer the following questions with a YES OR NO IN EACH CASE and give further details where required. PLEASE INITIAL AND DATE ANY AMENDMENTS TO THIS INFORMATION					
Are you currently taking any of the following medication ? OR Have you taken any of the following medication in the last 12 months? Please give details					
MEDICATION	✓	X	MEDICATION	✓	X
Antibiotics?			Warfarin / Aspirin?		
The Contraceptive Pill?			HRT?		
Chemotherapy medication			Medication known to be photosensitizing?		
Oral isotretinoin eg Roaccutane			Topical Isotretinoin eg Retin A / Renova?		
Epipen?			Respiratory Inhalers?		
Steroids?			Antidepressants		
Are you taking any other form of oral, topical or injectable medication? Please give details					

Please add any further details of your health and medical history that has not otherwise been covered in this questionnaire

CONFIRMATION OF DISCLOSURE

I hereby confirm that, I have completed / amended the consultation form contained in this document with full and accurate disclosure.

Date of Consultation	
Client Name	Client Signature
Practitioner name	Practitioner Signature
Tutor Name	Tutor Signature

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CLIENT TREATMENT RECORD

Client Name -

Date of Treatment	Treatment Description – Products/ Parameters		
Skin Reaction	Comments / Complications	Practitioner	Amount Paid
Products Purchased			

Date of Treatment	Treatment Description – Products/ Parameters		
Skin Reaction	Comments / Complications	Practitioner	Amount Paid
Products Purchased			

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