CLIENT REFERENCE

_____

DATE OF CONSULTATION

_____

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

CLIENT CONSULTATION FORM

Student Name

_____

Candidate Number

_____

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	

Which aesthetic facial treatments have you received in the past? How long ago and were you happy with the treatment?

- O Chemical peel _____
- O Micro- Needling _____
- O Laser / IPL Hair Removal _____
- O Laser IPL Skin Rejuvenation _____
- O Radio Frequency _____
- O Blemish Removal _____
- O Botulinum Toxin _____
- O Dermal Fillers _____
- O PDO Threads _____
- O Other – please state _____

Which of the following skin care products do you use regularly? Give Details

- O A Skin Cleanser _____
- O Exfoliant _____
- O Antioxidant Serum _____
- O Hydration Serum _____
- O Moisturising Cream _____
- O Retino _____
- O Condition Specific Products _____
- O Eye Treatment Product _____
- O SPF (Specify level) _____
- O UVA Sunscreen _____
- O Other – please state _____

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

Answer the following questions with a YES OR NO IN EACH CASE and give further details as required. **PLEASE INITIAL AND DATE ANY AMENDMENTS TO THIS INFORMATION**	
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		**CONDITION**	
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 as 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		**MEDICATION**	
Antibiotics		Warfarin/Aspirin	
The Contraceptive Pill		HRT	
Chemotherapy Medication		Medication known to be Photosensitising	
Oral isotretinoin e.g. Roaccutane		Topical Isotretinoin e.g. 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 been covered in this questionnaire.

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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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Skin Reaction	Comments/Complications	Practitioner	Amount Paid
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