

**FACE THERAPIES CONSULTATION FORM Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­ **Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Children**\_\_\_\_\_

**Address**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Occupation**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Next of Kin** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where did you hear about me? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I want to receive offers, tips & tutorials YES/NO

Doctor’s name/ Surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

About you

1. Reason for seeking treatment
2. How are you hoping to benefit from this natural & holistic facial?
3. How do you feel about your face and skin?
4. Would you like to increase your confidence and the way you feel about yourself?
5. Are you affected by stress?
6. How does stress manifest in you? Please give a detailed description for both the physical and mental/emotional aspects.
7. Do you experience tension in your face? Where exactly?
8. Do you experience tension in your neck and shoulders?
9. Do you experience eye strain?
10. Do you suffer from headaches? Please describe location and frequency
11. How do you feel about ageing?
12. Does getting old worry you? If yes in what way?

**About** your skin

1. Please describe your skin (concerns, issues, and condition) and what you would like to achieve
2. What is your usual skin care routine?
3. What are the areas of main concern?
4. Would you like to learn simple and effective techniques to use at home for lasting youthful look and to release tension in your face?

1. Would you be committed to a simple self care routine and learn how to **keep** your face fit and achieve optimal skin health?
2. Have you ever thought of having botox, fillings or cosmetic surgery done?

About your health

1. **Do you have any of the following conditions?**

 High temperature/fever High or low blood pressure

 Contagious skin disorders Thread veins

 Eye infections (e.g. conjunctivitis) Cysts / Warts

 Local pain such as toothache Serious medical conditions (specify?)

 Psoriasis or eczema Any condition not listed above?

If yes to any of the above, or other, please give details.

1. Women only:
* Is there any possibility you may be pregnant?
* How is your period? (Heavy? Painful? Irregular?)
* Are you aware of any hormonal imbalance (including polycystic ovaries?, Endometriosis or other conditions?)
1. Do you have any allergy?
2. Do you consider yourself to have a good diet?
3. How is your digestion?
4. Any supplement or medication taken?
5. How much plain water do you drink each day?
6. How many cups of tea and coffee do you drink each day?
7. What is your weekly alcohol consumption?
8. Do you smoke? How many a day?
9. Do you have any problem with your eyes?
10. Do you have any problem with your teeth?

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Thanks for filling this out in its entirety. Doing so will help you getting the most out of your treatment. I am so looking forward to working with you!

***The Therapist has explained the treatment and I consent to receive it.***

Signed (Client): Date:

**Would you like to receive a periodic newsletter with tips, offers and tutorials? YES/NO**

CLIENT FEEDBACK:

**The right skin type**

Your skin can change throughout the year, in response to emotions, stress, hormonal changes, medications and other system imbalances.

To tailor your treatment I need to know about your skin type. Please tick which are applicable to you.

 **Skin type Description Tick if appropriate to you**

Dry Feels tight after cleansing

 Matte finish

 Creases are visible

 Sensitive to cold

 Small pores fine texture

Sensitive Skin easily irritated & often red and blotchy

 Usually sensitive to weather and other trigger events

 Appears fine when healthy

 Reacts to harsh products

 Eczema

Psoriasis

Normal Blemishes are uncommon

 Appears plump/moist dewy

 Small pores

 Even skin tone

 Good elasticity

Minimal skin damage

Combination Different structure and appearance between

the t-zone and cheeks

 Occasional break-outs (usually hormonally linked)

Oily Always oily although dries with age

 Pores large and visible

 Thicker skin, not generally sensitive

 Visible sheen to skin

 Tendency to break -outs

Mature / damaged Feels tight especially in winter

 Visible fine lines

 Slack skin tone

 Skin can look leathery and dull

 Small pores fine texture

 Brocken capillaries

 Age spots

 Large pores

Your overall skin type is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For the Therapist use**

**Skin type** (dry, oily etc.)

**Skin Assessment** (colour, texture, condition)

*Visual:* -dry, dull skin, enlarged pimples, broken skin, thread veins, hyper-pigmentation, scarring, whiteheads, blackheads, etc.

*Touch:* rough skin, cold/hot

**Physiological signs** - colour, areas of puffiness, dry or greasy patches, spots etc.

**Psychological signs** -muscular tightness (which areas), lines…..

**MAIN DIAGNOSTIC PATTERNS Key Relevant symptoms**

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**Your Tailored Skincare Routine:**

**Cleanser:**

**Toner:**

**Compresses:**

**Therapeutic oil blend:**

**Moisturiser:**

**Exfoliant:**

**Eye care:**

**Mask or pack:**

**Treatments:**

**ESSENTIAL OILS ml/drops**

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**CARRIER OILS**

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**HYDROSOLS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**OTHER INGREDIENTS Quantities**

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**MASSAGE OUTLINES/CUPPING:**

HOME ADMINISTRATION METHODS:

**Your Tailored Skincare Routine**