Therapie Medspa

CONSULTATION FORM

HOW CAN WE BE OF HELP: ……?

WHAT IS YOUR SKIN CARE ROUTINE: MORNING NOON NIGHT?

WHAT ARE YOUR SKIN CARE GOALS?

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HOW DID YOU HEAR ABOUT US? _____

CONTRAINDICATIONS THAT RESTRICT TREATMENT (SELECT IF/WHERE APPLICABLE)

- ☐ FEVER
- ☐ CUTS/ABRASIONS/ SEVERE BRUISING
- ☐ UNDER THER INFLUENCE OF ALCOHOL
- ☐ DIARRHOEA OR VOMITING
- ☐ INFLAMATION
- ☐ ACTIVE HERPES/BACTERIA INFECTION
- ☐ LOCALISED SWELLING
- ☐ HORMONAL IMPLANTS
- ☐ HAEMATOMA
- ☐ ANY METAL PLATES OR PINS
- ☐ HYPERSENSITIVE SKIN/LOSS OF SENSATION
- ☐ SINUSITIS
- ☐ BOTOX/DERMAL FILLERS (1 WEEK FOLLOWING TREATMENT
- ☐ ANY KNOWN ALLERGIES
- ☐ SCAR TISSUE (2 YEARS MAJOR OPERATION & 6 MONTHS FOR A SMALL SCAR

TREATMENT TYPE:

☐	DEEP CLEANSING	☐	HYDRATING	☐	ANTI-AGING	☐	NOURISHING	☐	DETOXIFYING
☐	DE-SESITISING	☐	MOSTURIZING	☐	BALANCING/ NORMALISING	☐	REGUVENATING/ REGENERATING	☐	TIGHTENING

OTHERS: _____

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TREATMENT PLAN INCLUDING PRODUCTS TO BE USED: _____

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CLIENT FEEDBACK:

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AFTERCARE/HOMECARE ADVICE: _____

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RETAIL RECOMMEDATIONS: _____

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NEXT APPOINTMENT: _____