HEARTBREAKER SPA

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*Please complete this consultation form and bring it with you to your scheduled appointment or email directly to **spa@heartbreakersalon.com**.*

Full Name _____ Number _____

Profession _____ Email _____

In case of emergency, please contact _____

Age ☐ 18-25 ☐ 26-35 ☐ 36-45 ☐ 46-55 ☐ 56+

Is this your first facial treatment? ☐ yes ☐ no

How frequently do you have facials treatments?

☐ 1 x month ☐ 2 x month ☐ 1 x every 3 month ☐ 1 / 2 x year (irregularly)

YOUR HEALTH

This information is to ensure we carry out the appropriate treatments for you, taking into consideration any medical conditions which might have treatment contraindications.

Please indicate any of the following that apply to you:

☐ pregnancy	☐ eczema	☐ asthma	☐ psoriasis
☐ heart condition	☐ diabetes	☐ epilepsy	☐ rosacea
☐ dermatitis	☐ headaches/migraines	☐ skin cancer	☐ water retention
☐ menopause	☐ high blood pressure	☐ thyroid - hyper or hypo	☐ varicose veins

Any other medical conditions? _____

Are you taking any medications? _____

Do you suffer from any allergies? _____

Do you suffer from claustrophobia? _____

YOUR LIFESTYLE

How would you describe your stress levels from 1 - 10 (1=low, 10=high): _____

How frequently do you exercise:	☐ everyday	☐ 3 x week	☐ 1 x week	☐ never
How would you describe your diet:	☐ balanced	☐ on the run	☐ very unbalanced	
Do you smoke:	☐ yes	☐ no		
Do you live in a polluted environment:	☐ yes	☐ no		
Do you drink alcohol:	☐ daily	☐ occasionally	☐ never	
Do you drink coffee:	☐ 1 x day	☐ 2 x day	☐ more than 2 x day	

PRIVACY STATEMENT: The skincare history and health information you have provided is used to help our therapists recommend skin care treatments and homecare products that are suitable for your skin and condition. It is accessible to authorized staff for that purpose only and may be accessed by you at any time.

YOUR FACE

How do you find your skin? ☐ normal ☐ dry ☐ oily ☐ combination ☐ sensitive

Are you concerned with any of the following?

☐ pimples ☐ acne ☐ scarring ☐ oiliness ☐ dilated pores
☐ dullness ☐ sensitivity ☐ dehydration ☐ sun damage ☐ dyschromia
☐ under-eye puffiness ☐ dark circles ☐ wrinkles ☐ lack of tone ☐ sagging

What is your primary concern?

_____

Which areas concern you the most in terms of aging? ☐ face ☐ eye area ☐ hands ☐ décolleté

Have you ever experienced any of the following?

☐ chemical peels ☐ laser resurfacing ☐ retinol based products ☐ botox
☐ other skin corrective procedures: _____

Do you use any of the following?

☐ cleanser ☐ day moisturizer ☐ toner ☐ exfoliator ☐ mask ☐ eye cream
☐ soap ☐ night moisturizer ☐ sunscreen ☐ serum/concentrate/booster ☐ peels
☐ other: _____

YOUR BODY

Are you concerned with any of the following body conditions?

☐ weight ☐ loss of skin tone ☐ muscle tone ☐ elasticity ☐ bust area - lack of tone ☐ heavy legs
☐ dry skin ☐ cellulite ☐ stretchmarks ☐ varicose veins/broken capillaries ☐ dry feet ☐ dry hands

Do you use any of the following?

☐ body scrub ☐ body moisturizer ☐ cellulite products ☐ bust products ☐ hand cream ☐ foot cream

What is your primary concern?

_____

Date	Treatment Subscribed & Performed	Improvements/Concerns	Products	Next Appointment

Guest's Printed Name _____ Guest's Signature _____

Therapist's Printed Name _____ Therapist's Signature _____

Date _____