Client CONSULTATION FORM for LED Photo-Facial (or) Skin Care

Client Name: _____ **Date:** _____

The purpose of this is to identify the *needs* of your *skin*—so that we can give you the *best possible solutions.*

What challenges or concerns are you having with your skin right now? Please list ALL of them.

_____ _____ _____

_____ _____ _____

Have you had past treatments to address these concerns? Yes _____ No _____

If yes, what type? _____

If yes, what would you rate the effectiveness of the treatments on a scale of 1 – 10 *(10 being the best)* _____

How would you describe the *elasticity* of your *skin*?
a) Tight & firm b) Moderately firm c) Loosing elasticity d) Loose & saggy

How would you describe the *tone* of your *skin*?
a) Even b) Uneven c) Blotchy d) Discolored e) Red and/or irritated f) Sensitive

What would you rate the *condition* of your skin right now on a scale of 1 – 10 *(10 being the best)*? _____

What would you rate your commitment level to addressing these concerns on a scale of 1 – 10? _____

Would you like a temporary solution or a lifestyle plan? _____

Have you ever had a reaction to any skin care products? Yes ____ No ___ **If yes, can you tell me about it?**

Earlier I heard you rate the condition of your skin a _____. Can you tell me what you are currently using at home?

Cleanser: _____ Toner: _____

Day Cream: _____ Night Cream: _____

Eye Cream: _____ Exfoliates: _____

Mask: _____ Sunscreen: _____

Specialty/Other: _____

How much time do you spend taking care of your skin daily? _____

What is the ONE thing you *most* want to see *change* or *improve*? _____

The Top 3 Challenges I heard you say were:

1. _____
2. _____
3. _____

The Solutions I Recommend: (facials, skin care, mineral makeup)

_____

_____

_____

Name:____Goals: ____