Full name	
Date	

Environ
CONSULTATION CARD

ENVIRON®
a beautiful skin for a lifetime

Step 1: To be completed for the client

Date of birth	
Occupation	
Contact number	
Email address	
May we contact you with information which may be of interest to you? ⬡ Yes ⬡ No	
Referred by	
Contact number	

A 1 – About your skin:

1. What concerns you most about your skin? **Please tick** ☑

Ageing	Dehydration	Sensitivity	Pigmentation	Breakouts
⬡ Sun damage	⬡ Dry, flaky skin	⬡ Redness	⬡ Dark pigmented marks	⬡ Oily T-panel
⬡ Wrinkles	⬡ Tight skin	⬡ Rashes	⬡ Lighter depigmented marks	⬡ Oily skin
⬡ Fine lines	⬡ Rough texture	⬡ Reactive skin	⬡ Dark circles in the eye area	⬡ Enlarged pores
⬡ Thin skin		⬡ Dilated capillaries		⬡ Occasional breakouts
⬡ Sagging skin		⬡ Itchiness		⬡ Severe breakouts
				⬡ Uneven texture
				⬡ Scarring

2. Any other concerns?

A 2 – About your skin:

1. What is your present skincare routine?

List the brand and specific products being used	
⬡ Soap and water	
⬡ Pre-cleanser	
⬡ Cleanser	
⬡ Exfoliator	
⬡ Toner	
⬡ Serum	
⬡ Eye product	
⬡ Moisturiser	
⬡ Mask	
⬡ Sunscreen	
⬡ Other:	

A 3 – About your skin:

1. Have you recently had any of the following aesthetic procedures?

Procedure	Treatment Area	Date
⬡ Peels		
⬡ Facial waxing		
⬡ Botulinum toxin		
⬡ Fillers		
⬡ Microdermabrasion		
⬡ Laser resurfacing		
⬡ Cosmetic surgery		
⬡ Laser hair removal		
⬡ IPL		
⬡ Microblading		
⬡ None of the above		
⬡ Other:		

A 4 – About your skin:

1. Have you ever been treated with any of the following?

Treatment	Date
⬡ Cis-retinoic acid (Roaccutane®)	
⬡ Retin A®, Differin® Gel, Adapalene, Tretinoin, etc.	
⬡ Topical antibiotics	
⬡ Anti-fungal nail treatments	
⬡ Topical cortisone	
⬡ Benzoyl peroxide	
⬡ Salicylic acid	
⬡ Alpha hydroxy acids	
⬡ Hydroquinone	
⬡ None of the above	
⬡ Other:	

B 1 – Lifestyle:

1. General health: **Please tick** ☑

#	Question	Response
1.	Do you smoke?	⬡ Yes ⬡ No
2.	Are you on a specific diet?	
3.	Stress level	⬡ Low ⬡ Moderate ⬡ High
4.	Regular exercise	⬡ Yes ⬡ No
5.	How many glasses of water do you drink per day?	
6.	Sun exposure	⬡ Low ⬡ Moderate ⬡ High

C 1 – Medical profile:

1. Do you suffer from any of the following? **Please tick** ☑

- ⬡ Fever blisters
- ⬡ Sinusitis
- ⬡ Allergies e.g. Aspirin®: _____
- ⬡ Food intolerances
- ⬡ Claustrophobia
- ⬡ Cardiac irregularities
- ⬡ Diabetes Type 1/2
- ⬡ High cholesterol
- ⬡ High/low blood pressure
- ⬡ Thyroid condition
- ⬡ Epilepsy
- ⬡ Lupus
- ⬡ None of the above
- ⬡ Other: _____

2. Do you suffer from any of the following skin disorders? **Please tick** ☑

- ⬡ Psoriasis
- ⬡ Eczema
- ⬡ Keloid scarring
- ⬡ None of the above
- ⬡ Other: _____

3. Do you have a pacemaker? ⬡ Yes ⬡ No
4. Do you have metal implants? ⬡ Yes ⬡ No
5. Do you have braces? ⬡ Yes ⬡ No
6. Do you wear contact lenses? ⬡ Yes ⬡ No
7. Are you currently taking any of the following? (Please specify)

- ⬡ Medication:
- ⬡ Nutritional supplements:

D 1 – Female clients:

1. **Please tick** ☑

- ⬡ Hormonal imbalance (polycystic ovarian syndrome, endometriosis, etc.): _____
- ⬡ Contraceptive: _____
- ⬡ Hormone replacement therapy: _____
- ⬡ Are you pregnant? ⬡ Yes ⬡ No
- ⬡ Are your lactating? ⬡ Yes ⬡ No
- ⬡ Are you planning pregnancy? ⬡ Yes ⬡ No

E 1 – Male clients:

1. **Please tick** ☑

Shaving method: _____

Irritation from shaving? ⬡ Yes ⬡ No

Step 2: Client permission

Please sign by clicking on the box below.

Client signature: ⬡ _____

(parent/guardian if applicable)

Skincare professional signature: ⬡ _____

Date: _____