

**Guest Consultation Form For Skin Care**

**Guest Name:** \_\_\_\_\_

**Sex:** Female \_\_\_ Male \_\_\_

**Email:** \_\_\_\_\_

**Phone:** Home: \_\_\_\_\_ Mobile: \_\_\_\_\_

**Date:** \_\_\_/\_\_\_/\_\_\_

**Birthdate:** \_\_\_/\_\_\_/\_\_\_

**How did you hear about us?** \_\_\_\_\_

**May we add you to our email list? Y/N**

**AGE:** Under 20      20-30      30-40      40-50      50-60      60+

**GUEST INFORMATION:**

**Within the last year have you been under a physician's care?** \_\_\_\_\_

**Within the last year have you been under a dermatologist's care?** \_\_\_\_\_

**Within the last six months have you undergone any surgery?** \_\_\_\_\_

**If yes, please specify:** \_\_\_\_\_

**List any medications, supplements, vitamins, or diuretics that you take regularly (please list):**

**Are you pregnant?** \_\_\_\_\_

**When was your last facial, skin care, or bodywork treatment?** \_\_\_\_\_

**What are your skin care goals?** \_\_\_\_\_

**What are your concerns regarding today's treatments?** \_\_\_\_\_

**Please list any operations or serious illness in the past 5 years:**

**Do you suffer from any of the following illnesses or diseases:**

- |                  |                    |                    |
|------------------|--------------------|--------------------|
| Lupus            | Topical Steroids   | Photosensitive Med |
| Cancer           | Bleeding Disorders | Hormonal Med       |
| Keloid Scars     | Clotting Disorders | Herbal Remedies    |
| Hypopigmentation | Systemic Diseases  | Cold Sores         |
| Diabetes         | Cardiac Disease    | Migraine           |
| Roacutanne       | Hyperpigmentation  | Active Tan         |
| Skin Disorders   | Hormonal Imbalance | Polycystic Ovaries |
| Epilepsy         | Eczema             | Psoriasis          |
| Lumps/Cysts      |                    |                    |

**Have you used/are you using Rx products /medications? (Roacutane, Birth control pills or hormones)** \_\_\_\_\_

**Have you/are you using Retin A?** \_\_\_\_\_

**Do you suffer from depression?** \_\_\_\_\_

**Are you allergic to latex? (If yes please elaborate on the severity of previous reactions)**

**Do you have any other allergies/intolerances to foodstuffs, drugs, chemicals, etc?**

**Describe your skin (choose all that apply):**

- |             |                |                      |           |
|-------------|----------------|----------------------|-----------|
| Normal      | Uneven/Blotchy | Acne                 | Cystic    |
| Oily        | Mature         | Milia                | Sallow    |
| Combination | Wrinkled       | Blackheads           | Pigmented |
| T Zone      | Saggy          | Occasional Breakouts |           |
| Oily/Dry    | Firm           | Rosacea              |           |

**Cont. Skin...**

Freckled  
Sun-damaged

Large Pores  
Small Pores

Scarred  
Melasma

What problems do you have with your skin? \_\_\_\_\_

What products are you using at the moment? \_\_\_\_\_

What type of skin do you think you have? \_\_\_\_\_

What would you like to see improved with your skin? \_\_\_\_\_

What is your daily skin care routine? \_\_\_\_\_

Do you use a high quality sunscreen/sunblock daily or regularly? \_\_\_\_\_

How much sun exposure have you had in the past?      Extreme      Moderate      Rarely

Do you or have you in the past used sunbeds?      Never      Sometimes      Regularly

How do you rate your health at the moment? \_\_\_\_\_

Do you smoke? \_\_\_\_\_ How many a day? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ How many glasses a week? \_\_\_\_\_

How would you rate your diet/eating habits? \_\_\_\_\_

Please list: \_\_\_\_\_

Do you eat oily fish regularly? \_\_\_\_\_

Do you eat 5 portions or more of fruit and vegetables daily? \_\_\_\_\_

How much red meat do you eat? \_\_\_\_\_

Roughly, how many dairy products do you consume in a week? \_\_\_\_\_

Do you eat any soya products and if so, what kinds and how often? \_\_\_\_\_

Have you taken antibiotics in the past 2 years? \_\_\_\_\_ For how long? \_\_\_\_\_

Are you breastfeeding or planning a pregnancy in the near future? \_\_\_\_\_

Do you have any hormonal problems and do you suffer from PMT symptoms? \_\_\_\_\_

Is your energy level good? \_\_\_\_\_

Please add any more information below if you feel we should know more about you, your lifestyle and your desired results from our treatments:

From 1-10 please rate your stress level. \_\_\_\_\_

#### GUEST RELEASE

I confirm to the best of my knowledge that the information I have provided is accurate and complete. I have not withheld any information that may be relevant to my treatment and/or results thereof. I am aware that there are inherent risks associated with skin/massage care services and bodywork. The services I am about to receive could have contraindications which could result in allergic reaction, irritation, burning, redness, soreness, etc. By signing below, I further agree that I will not hold Orange Skye Day Spa or its affiliates or any of its employees responsible should there be any unfavorable outcome or result.

Please note that all guests are considered late 15 minutes after the appointment time. It maybe necessary to reschedule your appointment. We require a 24 hour cancellation notice or service appointment will be charged.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Parent or Guardian Signature \_\_\_\_\_  
(If under 18)

Date \_\_\_\_\_