International iiaa® Institute for Anti-Ageing

CLIENT CONSULTATION

PERSONAL DETAILS

Name Date

Address

Date of birth

Phone number

E-mail

YOUR HOST SALON/CLINIC IS

L BEAUTY
1-5 Bankfield Drive
Spondon
Derby DE21 7QZ
reception@lbeauty.co.uk | 01332 661 031 | www.lbeauty.co.uk

WELCOME TO HEALTHY SKIN

1: PLEASE ANSWER THE FOLLOWING HEALTH QUESTIONS

Are you prone to any of the following?

	Yes	No
Psoriasis	☐	☐
Eczema/Dermatitis	☐	☐
Rosacea	☐	☐
Keloid scarring	☐	☐
Herpes Simplex	☐	☐

If you are, where and how long?

Please indicate are you or do you have any of the following

These conditions are contraindicated to the Environ® DF Ionzyme® electrical treatments.

**These require doctors consent*

	Yes	No
Pregnant	☐	☐
Pacemaker	☐	☐
Porphyria	☐	☐
Diabetic*	☐	☐
Epilepsy*	☐	☐
Cardiac Irregularities*	☐	☐
Metal Plate/Pins	☐	☐
Radiotherapy*	☐	☐
Chemotherapy*	☐	☐
Moles or Sun Spots Removed*	☐	☐
History Thrombosis/Embolism*	☐	☐
Circulatory Disorders*	☐	☐
Multiple Sclerosis*	☐	☐
Any other medical conditions – please specify	☐	☐
Any known allergies– please specify	☐	☐

Sonophoresis Caution:

Hearing implants	☐	☐
Tinitus	☐	☐

Have you been treated with any of the following?

	Yes	No
Hormone Replacement Therapy	☐	☐
Bioidentical Hormone Replacement Therapy	☐	☐
Contraceptive Pill	☐	☐
Topical Corticosteroids	☐	☐
Oral Corticosteroids	☐	☐
Topical Antibiotics	☐	☐
Oral Antibiotics	☐	☐
Topical Vitamin A *(Retin A)*	☐	☐
Roaccutane	☐	☐
Acne Medication *(e.g. Benzoyl Peroxide, Azelaic Acid, Alpha Hydroxy Acids)*	☐	☐
Blood Thinning Medication *(e.g Warfarin)*	☐	☐

Any other medication – please specify

If you have answered yes, please indicate when and for how long

Please indicate if you are having or have had any of the following

	Yes	No
CST *(Immediately after treatment)*	☐	☐
IPL *(Immediately after treatment)*	☐	☐
Laser Treatments *(Wait 2 weeks)*	☐	☐
Microdermabrasion *(Immediately after treatment)*	☐	☐
Electrolysis *(Wait 2-3 days)*	☐	☐
Facial Waxing	☐	☐
Botox *(Wait 2 weeks)*	☐	☐
Fillers *(Consult Practitioner)*	☐	☐

Other skincare treatments

If you have answered yes, please indicate when and where

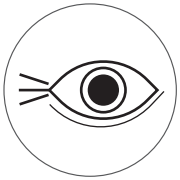
Thank you, your therapist will now take you through the next steps

2: YOUR CONCERNS AND SKIN TYPE

Tell me what are your main concerns?

Lines and wrinkles ☐

Dark spots ☐

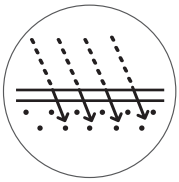


Eye area ☐

Dryness/dehydration ☐

Firming/lifting ☐

Redness/sensitivity ☐



Sun damage ☐

Visible pores ☐

Lack of radiance ☐

Scarring/texture ☐

Oil control ☐

Blemish prone ☐

Show me where you are noticing this

Notes:

Please take before and after photographs

2: YOUR CONCERNS AND SKIN TYPE

Tell me which vitamins and supplements you take? Do you take any for your skin?

Tell me more about your skin care and make-up routine

Eye Make-Up Remover ☐
Pre-Cleanser ☐
Cleansers & Toners ☐

Exfoliators/Masks ☐

Eyes ☐

Serums ☐

Moisturisers ☐

Sun Protection ☐

Body ☐

Treatments/Facials ☐

Foundation ☐

Eyes ☐

Cheeks ☐

Lips ☐

3. YOU AND YOUR LIFESTYLE

How do your cheeks look and feel?

Dry	Sensitive	Comfortable	Shiny	Oily
☐	☐	☐	☐	☐

How does your T Zone look and feel?

Dry	Sensitive	Comfortable	Shiny	Oily
☐	☐	☐	☐	☐

How does your eye area look and feel?

Dark circles	Lines/wrinkles	Puffiness	Firming/lifting	Sensitive
☐	☐	☐	☐	☐

Describe the environment that your skin lives in

Urban _____ ☐

Frequent Travel _____ ☐

Suburban _____ ☐

Office _____ ☐

Outdoor Activities _____ ☐

Air Conditioning _____ ☐

3. YOU AND YOUR LIFESTYLE

What kind of sun exposure do you get?

Very Low (Incidental exposure from walking)	Low	Moderate	High	Very High (Extended Exposure from being outside)

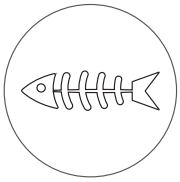
On average how many hours of sleep do you get a night?

Less than 4hrs	5hrs	6hrs	7hrs	8hrs or more

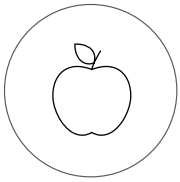
How would you describe your stress levels?

Very Low	Low	Moderate	High	Very High

Tell us about your diet & lifestyle

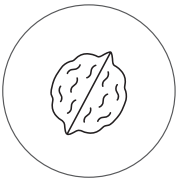


Oily Fish _____ per week

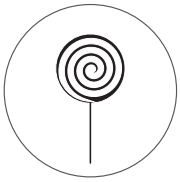


Fruit & Veg _____ per day

Water Intake _____ per day



Nuts & Seeds _____ per day



Refined Sugar _____ per day

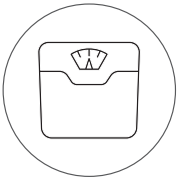
Smoker _____ per day

Tea &/or Coffee _____ per day

Alcohol _____ per week

Vegetarian _____

Vegan _____



Diet _____

Breast Feeding _____

4: LET'S RECAP

Your main concern is:

Your skin type is:

Your skin goals are:

Your Personal Information

Except for where you have separately granted iiaa permission to store and process your before and after photographs and face scan data, iiaa itself does not store or process your other personal and medical data as captured on this record card - please liaise with the salon direct to understand its arrangements for data security and compliance with data legislation.

TO THE BEST OF MY KNOWLEDGE THE MEDICAL INFORMATION IS RELEVANT AND FACTUALLY CORRECT.

Date Signature

5. YOUR TREATMENT PLAN

First visit

Date Treatment

Therapist Name

Products used

Follow up visit or treatment

Health Review

Undertaken by [salon or iiaa employee]: Date

☐ The Client's health data was unchanged since the last visit ☐ The Client's health data changed as described below:

Declaration: This form including any additional data described above is an accurate reflection of my current health and discloses all relevant medical conditions.

Client Name: Signature: Date:

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