NAT.

Natural skin & body essentials

CLIENT PROFILE . **PRIVATE AND CONFIDENTIAL**

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ww.natskinbody.com

"Revitalise with the Best from Nature and Science"

DATE	TREATMENT	TREATMENT CHARGE	PRODUCT PURCHASED	PRODUCT CHARGE	SAMPLE GIVEN	THERAPIST (INITIALS)

CLIENT PROGRAM **HISTORY**

Client Name: _____

Date of Consultation: _____ **Therapist's Name:** _____

Address: _____

_____ Postcode: _____

Telephone (W): _____ (H): _____ Email: _____

BIRTHDAY _____ day _____ month ☐ Under 21 ☐ 21-30 ☐ 31- 40 ☐ 41-50 ☐ Over 50

How did you hear of us? _____

This information should be completed by all NAT. Skincare clients for diagnostic purposes. This enables the beauty therapist to cater for the client's special needs, in both salon treatment and home maintenance to the best of the therapist's ability.
All information given is **completely confidential**.

YOUR SKIN TYPE **PROFILE**

Please tick the boxes that best describe your skin type. This will determine the right NAT. Treatment Ritual for you.

1. Tendency Toward Oily/Acne
- ☐ Breakouts
- ☐ Blackheads & Congestion
- ☐ Open pores
- ☐ Active oil flow

2. Tendency toward Combination/ Congested
- ☐ Oily T-Zone
- ☐ Blackheads & Congestion in T-zone
- ☐ Dry/dehydrated cheeks
- ☐ Open Pores in T-zone

3. Tendency toward Dry/Devitalised
- ☐ Flaking
- ☐ Minimal Oil flow
- ☐ Fine lines
- ☐ Dehydration

4. Tendency toward mature sun/damaged
- ☐ Uneven texture & skin tone
- ☐ Deep lines
- ☐ Redness/broken capillaries
- ☐ Flaking/dehydration

How much time are you willing to devote to your facial skin?
AM: _____
PM: _____
Weekly: _____

What products are you currently using?
_____
_____
_____

Are you happy with the results?
☐ Yes ☐ No
Comments: _____

Have you ever had any allergic reactions to:
- ☐ Cosmetics ☐ Pollen
- ☐ Animals ☐ Medicine
- ☐ Food ☐ Salon Treatments
- ☐ Fragrance ☐ Sunscreen
- ☐ Iodine ☐ Other?

Do you have any concerns with your body?
_____
_____

What body products are you currently using?
_____
_____
_____

Have you ever had spa body treatment before?
☐ Yes ☐ No
Which ones?
_____

LIFESTYLE **QUESTIONS**

How much water do you consume daily?
_____

Do you take laxative or diuretics?
☐ Yes ☐ No

Do you Use Retin-A?
☐ Yes ☐ No

Do you use Roaccutane?
☐ Yes ☐ No

How many cups of coffee do you consume?
- ☐ 1-2
- ☐ 3-4
- ☐ More (daily)

Do you take stimulants or slimming tablets?
☐ Yes ☐ No

Alcohol consumption
- ☐ Low
- ☐ Moderate
- ☐ High
- ☐ None

Do you smoke?
☐ Yes ☐ No

Do you have regular sleep patterns?
☐ Yes ☐ No

Do you sunbathe?
☐ Yes ☐ No

Do you burn easily in sunlight?
☐ Yes ☐ No

Do you use a sunblock on your skin when you sunbathe?
☐ Yes ☐ No

Do you use a solarium?
☐ Yes ☐ No

Do you exercise regularly?
☐ Yes ☐ No

Do you feel stressed?
☐ Yes ☐ No
At what level? _____
(1 is lowest, 5 is highest)

Are you currently on a restricted diet?
☐ Yes ☐ No

Have you ever had any of these health concerns past or present?
- ☐ Cancer ☐ Diabetes
- ☐ Epilepsy ☐ Heart Problems
- ☐ Hormone imbalance
- ☐ Hysterectomy ☐ Thyroid
- ☐ Asthma ☐ Varicose Veins
- ☐ Sinusitis ☐ Cold Sores

Do you have any metal implants?
☐ Yes ☐ No

Do you have a pacemaker?
☐ Yes ☐ No

Are you presently on any medication?
Please list: _____
_____
_____
_____

Are you taking any vitamin/herbal supplements?
Please list: _____
_____
_____

FEMALE CLIENTS **ONLY**

Are you taking oral contraceptives?
☐ Yes ☐ No

Are you pregnant or trying to become pregnant?
☐ Yes ☐ No

Signature:
_____

Date:
_____