Megaroma Wellness Centre

SKIN CONSULTATION FORM

Name:_____ Date:_____

Address:_____

City:_____ Province:_____

Postal Code:_____Occupation:_____

Home Phone:_____Cell Phone:_____

Email:_____

Birthday:_____

Let me thank the person who referred you:_____

_____Yes, I'd like to receive emails from Megaroma Wellness regarding promotions.
_____No, Thank you.

SKIN CARE HISTORY

What is it that you would like to change or improve about your skin:

_____

_____

Please circle all that apply:

Discoloration	**Acne/Breakouts**	**Open sores**
(Brown spots)	**Fine lines/Wrinkles**	**Acne Scarring**
Dry, flaky skin	**Oily skin**	**Rosacea**
Sun Damage	**Lax or Sagging Skin**	**Dark Under Eye**
Eczema	**Cold Sores**	**Psoriasis**

What type of skin do you think you have?

Dry:_____Normal:_____Combination:_____Oily:_____

Do you use tanning beds?: YES OR NO
If so, how often?: _____

Have you ever had a reaction to any skin care product or cosmetic?
Yes:_____NO:_____

If yes, please list:_____

_____

Are you currently using a prescribed skin medication?
Yes:_____No:_____

If yes, please list:_____

_____

What skin care do you currently use?:_____

_____

Have you had any of the following?: Please circle all that apply

Chemical Peels **Permanent Cosmetics** **Electrolysis**

Laser Hair Removal **Microderm Abrasion** **Waxing**

Facial Cosmetic Surgery **Facial Injectibles**

If yes, when, and were there any complications?:_____
_____
_____
_____

Are you currently taking any medications or herbal supplements?:
Yes:_____No:_____

If you have any known allergies, please list them:_____
_____
_____
_____

What products would you be interested in for your skin care?
Please circle all that apply:

Body wash **Bubble Bath** **Body Moisturizer**

Face Regiment: (Cleanser; Toner; Cream or Lotion)

Facial Scrub **Body Lotion** **Bath Salts**

Eye Serum **Hand Sanitizer** **Sunburn relief**

Go-Away Spray: (Children; Adult) **Cold Sore Med**

Bug Bite Relief **After shave** **Beard Oil**

Cologne **Perfume Roll-on**

Are you pregnant or breastfeeding? Yes:_____No:_____

Are you on birth control pills?:Yes:_____No:_____

Is there anything else that should be known before we choose your skin care products?_____

_____

_____

_____

I understand , have completed this questionnaire truthfully. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from products/treatments received. The treatments/products that I receive here are voluntary and I release Megaroma Wellness Centre and Elaine Steeves from liability and assume full responsibility thereof.

Client signature:_____

Aromatherapists signature:_____

Date:_____