

Guest Consultation Questionnaire

Confidential client consultation • Please complete all applicable sections.

Client & Appointment Information

Date: _____ **Date of birth:** _____

Client full name: _____

Preferred phone number: _____

Email address: _____

Address (optional): _____

Occupation / type of work: _____

Typical work environment (check all that apply):

- ☐ Mostly indoors / desk
 ☐ Outdoors / sun exposure
- ☐ Dusty or dirty environment
 ☐ Heat / perspiration
- ☐ Other: _____

Referred by: _____

What would you like to achieve from your treatment?

Previous Treatments

	NO	YES
1. Have you previously had a facial treatment?	☐	☐
If yes, approximately when?		
2. Have you previously had a body spa treatment?	☐	☐
If yes, approximately when?		

Treatments (check all that apply):

- ☐ Massage
 ☐ Salt glow
- ☐ Seaweed wrap
 ☐ Moor mud
- ☐ Body scrub
 ☐ Other: _____

Skin Type

3. Which description best matches how your skin responds to sun exposure? Circle one number.

I	Very fair / creamy — burns easily; does not tan
II	Fair / light — usually burns; tans minimally
III	Light / medium — may burn; gradually tans
IV	Medium / olive — rarely burns; tans well
V	Brown — rarely burns; tans deeply
VI	Deep brown / dark — rarely burns; deeply pigmented

Guest Consultation Questionnaire

Continued • Skin history, products, and recent treatments

Skin History & Treatment Precautions

	NO	YES
4. Do you currently have skin concerns or conditions affecting your face or body?	☐	☐
If yes, describe: _____		
5. Have you ever had a chemical peel, laser treatment, or microdermabrasion?	☐	☐
6. Have you had any of those treatments within the past month?	☐	☐
7. Do you currently use retinoids or exfoliating acids (such as Retin-A, Renova, adapalene, retinol, or AHAs)?	☐	☐
If yes, which product(s)? _____		
8. Have you used any of those products in the past three months?	☐	☐
9. Have you taken or used medication for acne?	☐	☐
If yes, medication / product: _____		
When was it last used? _____		

Daily Skin-Care Products

10. What skin-care products do you currently use? Include brand names when known.

Soap: _____	Shower gel: _____
Toner: _____	Body lotion: _____
Mask: _____	Sunscreen: _____
Eye product: _____	SPF used: _____
Cleanser: _____	Night moisturizer / cream: _____
Day moisturizer: _____	Other: _____
Exfoliator: _____	Makeup products: _____
Scrub: _____	

Recent Exposure & Hair Removal

	NO	YES
11. Have you recently used self-tanning products or treatments?	☐	☐
If yes, specify: _____		
12. Have you used any hair-removal method during the past six weeks?	☐	☐
If yes, check all that apply:		
☐ Shaving	☐ Waxing	
☐ Electrolysis	☐ Plucking / tweezing	
☐ Threading	☐ Depilatory cream	

Guest Consultation Questionnaire

Continued • Skin concerns, allergies, and recent exposure

Skin & Eye Concerns

13. Which skin concerns would you like to address? Check all that apply.

- | | |
|--|--|
| ☐ Breakouts / acne | ☐ Uneven skin tone |
| ☐ Blackheads / whiteheads | ☐ Sun damage |
| ☐ Excess oil / shine | ☐ Wrinkles / fine lines |
| ☐ Rosacea | ☐ Dull or dry skin |
| ☐ Broken capillaries | ☐ Flaky skin |
| ☐ Redness | ☐ Dehydration |
| ☐ Brown spots / discoloration | ☐ Other: _____ |

Around the eyes:

- | | |
|------------------------------------|---------------------------------------|
| ☐ Dryness | ☐ Wrinkles |
| ☐ Puffiness | ☐ Dark circles |

Lips: ☐ Dryness ☐ Chapped / cracked ☐ Other: _____

Allergies & Reactions

14. Have you experienced allergic reactions to any of the following? Check all that apply.

- | | |
|--------------------------------------|---|
| ☐ Cosmetics | ☐ Alpha hydroxy acids (AHAs) |
| ☐ Medications | ☐ Fragrance |
| ☐ Foods | ☐ Shellfish |
| ☐ Animals | ☐ Latex |
| ☐ Sunscreens | ☐ Iodine |
| ☐ Pollen | ☐ Other: _____ |

Describe any reaction(s), including severity:

Sun Exposure & Injectable Treatments

15. Sunscreen used on face

SPF: _____ **How often?** _____

16. Sunscreen used on body

SPF: _____ **How often?** _____

	NO	YES
17. Has recent sun exposure or tanning-bed use changed your skin color?	☐	☐

If yes, describe: _____

18. Have you had Botox, Restylane, collagen, or other injectable treatments?	☐	☐
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If yes, treatment and date: _____

Guest Consultation Questionnaire

Continued • Additional treatment considerations and acknowledgement

Additional Treatment Considerations (if applicable)

Please answer only the questions relevant to you. You may discuss sensitive answers privately with your esthetician.

	NO	YES
19. Are you currently using oral contraceptives?	☐	☐
20. Have you recently started, stopped, or changed hormonal contraception?	☐	☐
21. Are you pregnant or trying to become pregnant?	☐	☐
22. Are you currently breastfeeding?	☐	☐
23. Are you experiencing menopausal skin changes or symptoms relevant to treatment?	☐	☐
24. Are you receiving hormone replacement therapy?	☐	☐

Details, if relevant to treatment: _____

Shaving & Irritation (if applicable)

25. What shaving method do you use? ☐ Wet shave ☐ Electric ☐ Other: _____

	NO	YES
26. Do you experience irritation or ingrown hairs after shaving?	☐	☐

Appointment Contact Preferences

	NO	YES
27. May we contact you by phone to confirm future appointments?	☐	☐
28. May we contact you by email or mail about studio news and promotions?	☐	☐

Additional Notes

Use this space for any additional information. Refer to question numbers when helpful.

Client Acknowledgment

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof.

Client signature: _____

Date: _____