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

The Treatment Rooms
13 High Street
Shrivenham
SN6 8AN

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

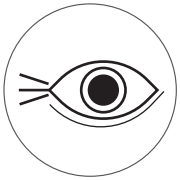
Thank you, your therapist will now take you through the next steps

2: YOUR CONCERNS AND SKIN TYPE

Tell me what are your main concerns?

Lines and wrinkles ☐

Dark spots ☐

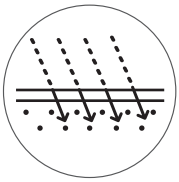


Eye area ☐

Dryness/dehydration ☐

Firming/lifting ☐

Redness/sensitivity ☐



Sun damage ☐

Visible pores ☐

Lack of radiance ☐

Scarring/texture ☐

Oil control ☐

Blemish prone ☐