Consultation Form

MAKEUP CLIENT

Donna Louise

CLIENT

Appointment Date & Time

Name

Address

Email

Phone Number

Age ☐ Under 18 ☐ 18-24 ☐ 25-39 ☐ 40-60 ☐ 60+

EMERGENCY CONTACT

Name

Phone Number

MEDICAL

How would you describe your skin type

☐ Normal ☐ Dry ☐ Oily ☐ Combination

☐ Sensitive ☐ Acne-prone ☐ Mature

Have you ever had any allergies to any makeup, skincare or cosmetic products?

☐ Yes ☐ No

If yes, then please describe

Have you recently had any facial procedures such as chemical peels, facials, microdermabrasion, laser or botox/filler?

☐ Yes ☐ No

If yes, then please describe

Do you have any problems with your skin (face and body), or any conditions I should know about?

☐ Yes ☐ No

If yes, then please describe or outline below

☐ Acne ☐ Eczema ☐ Dermatitis

☐ Psoriasis ☐ Rosacea ☐ Dehydrated skin

☐ Sun Damage ☐ Uneven Tone ☐ Enlarged pores

☐ Dark circles ☐ Hyperpigmentation ☐ Sensitivity to Products

☐ Broken capillaries ☐ Papules ☐ Skin cancer