



CONSULTATION FORM

If you are new to the salon please also fill in this consultation form. All information remains strictly confidential.

Name *

First Name

Last Name

Email *

Address

Address 1

Address 2

City

County

Zip/Postal Code

Country

Mobile Number *

Within the last year have you been under a doctor's care? Please explain. *

Please let us know any medical history. *

Any medical history past, present or underlying please list here.

Please list any medication, supplements, contraceptives etc that you are taking *

List all medication etc listed here even if you think it doesn't matter. The more information we have, the better.

Do you have any allergies? *

Any allergies currently or underlying list here

What is your occupation? *

How often do you exercise?

Do you smoke?

How stressed do you feel on a scale of 1-10? With 10 being the worst.

Have you been on Roccutane or Retin-A in the last 6 months?

If you are pregnant, how many weeks?

How much caffeine do you have daily?

How much water do you have daily?

I confirm this is the correct information best to my knowledge and agree to notify The Garden Retreat of any changes. *

I confirm

Sign *

.....

Name

Today's date