Simply Organic Skincare

Facial Consultation Form

Today's Date_____ Birthday _____/_____/_____

Name_____

Address_____

City_____ State_____ Zip_____

Cell Phone (_____)_____ Email_____

How did you hear about us?_____

What is your occupation?_____

Have you ever had a facial?_____ Do you currently get *regular* facials? _____

If yes, how often?_____

Do you have any current medical conditions? _____

If yes, please list:_____

Are you taking any prescription medications, either topical or internal? _____

If yes, what? Topical_____ Internal_____

Do you smoke? _____ If yes, how much per day?_____

Do you get oily during the day? _____ If yes, what time of day? _____

How much water do you drink daily? _____ Caffeinated beverages daily?_____

How much alcohol do you drink *weekly*? ____None ____1-3 ____4+

Allergies? Please list:_____

Do you consider your skin to be sensitive? _____

Describe your current skin care routine **(***please list brands***)**:

Cleanser_____ Toner_____ Scrub_____ Mask_____

Serum_____ Moisturizer_____ Sun block_____

What are your goals for your skin?_____

_____