Skin Consultation Form

Please complete this form to the best of your knowledge.

The consultation process may seem intense or in depth at times, however, I believe you deserve to be treated holistically. It is important for me to consider every aspect of your health, wellness and lifestyle to determine the most suitable treatment options in order for you to achieve the best possible outcome to your goals.

All information will be kept confidential at all times.

PERSONAL INFORMATION

Name
Sneha Sethi

Date of birth
23/12/1987

Occupation
Researcher

Phone
0426169283

Email
sneha.sethi@adelaide.edu.au

Address
2 Gifford street, South Plympton, SA 5038

Medical Pracitioner Details
-

Referred/recommended by OR how did you find us?
Instagram

Reason for visit
Pregnancy face care

EMERGENCY CONTACT DETAILS

Name
Pratul Aggarwal

Phone
0415461778

Relationship
Husband

The next few sections will allow your therapist to offer you the most comprehensive treatments to meet your specific needs & ensure you do not receive unsuitable treatments/products.

DIET, LIFESTYLE & GENERAL HEALTH

Are you currently:
Pregnant

If you are pregnant, do you suffer from morning sickness or have sensitivity to smell?
Both

Do you have any allergies?
No

Do you have any auto-immune conditions?
No

Are you currently under the care of a medical or natural health professional for any conditions or illnesses?
No

Are you currently taking any supplements or medications (ie. oral contraceptives, vitamins, etc)?
Yes

Please list any supplements or medications you are currently taking:
Vitamin d, iron

What is your current daily intake of the following:

Water	Tea	Coffee	Cordial / Soft Drink	Alcohol
2	0	1	1	0

Do you smoke?
No

Do you live with a smoker?
No

Do you eat a lot of sugary foods?
No

Do you suffer from bloating, constipation or digestive discomfort?
Yes

If YES, how often?
Everyday

What type and how often do you exercise each week?
Mild exercise - everyday, water exercises- 1/2 times a week

Do you have a regular sleep pattern / feel you get an adequate amount of sleep?
No

Average hours sleep per night:
5-6

Select your current level of stress

SUN EXPOSURE

When you go into the sun, do you (select one):
rarely burn

Is SPF (sun protection) important to you?
Yes

Do you apply SPF daily?
No

SKIN HISTORY & ROUTINE

How do you feel about the overall quality of your skin?
4

Are you concerned about any of the following?
Sensitivity
Acne / Breakouts
Dullness
Dryness
Redness

During the day, does your skin (select any that apply):
sometimes feels tight on cheeks
feels tight all over

What skincare brand(s) / product line(s) are you currently using?
None

Describe your current skincare routine and/or list the products you are using in the MORNING?
Na

Describe your current skincare routine and/or list the products you are using in the EVENING?
Na

Would you like a tailored treatment plan or recommendations for treatments and/or products that your therapist believes would benefit you and any presenting concerns you may have?
Yes

What is your monthly budget for skincare products and/or in clinic treatments (if required)?

Are you currently using or have you used any of the following in the past 12 months?

Antibiotics	Retin-A	Roaccutane	Hydroquinone
No	No	No	No

Hormone Replacement Therapy (Menopause Treatment)
No

Contaceptive Pill
No

Do you have a pacemaker?
No

Do you have any metal implants?
No

Do you have any specific treatment goals or other information you wish to share with your therapist?
No

FINAL STEPS

Do you give consent for your therapist to take photos to track your skin's progress throughout your skin journey?
Yes

Are you happy for Bump & Beyond Beauty to use your treatment results for advertising (ie. social media)? We will always do our best to ensure your identity is hidden and allow you to preview the images before sharing.
Yes

Would you like to hear about any other treatments / services offered by Bump & Beyond Beauty?
Massage
Facials
Advanced Qi Beauty Treatments
Pregnancy Treatments

Thankyou for completing this Skin Consulation Form.

The information provided will allow your therapist to provide the most suitable products/treatments for optimum results.

Please acknowledge and agree the following by responding YES

The information I have provided regarding my current and prevous medical history is accurate to the best of my knowledge and I affirm that I do not have any ailments or conditions that would make this treatment incompatible with my health and wellbeing.
Yes

I understand that this form and it's data are completely confidential
Yes

By selecting YES, I certify that I have been given the opportunity to ask any questions I may have and those questions have been answered. I acknowledge the information given to me pertaining to the requested treatment and I have been sufficiently informed of the benefits and risks involved (if applicable); that I am at least 18 years of age and fully competent to give my consent or have been given consent by parent or guardian.
Yes

I agree to inform my therapist if I experience any pain, discomfort or sensitivities during treatment, allowing them to make the appropriate adjustments.
Yes

Please type your full name as signature
Sneha Sethi