THE YASMIN METHOD

CLIENT CONSULTATION & SKIN ASSESSMENT FORM

Please answer all questions honestly. The information you provide will help me tailor your treatment safely and effectively.

Date: _____

Appointment Date: _____

SECTION 1: CLIENT INFORMATION

Full Name: _____

Date of Birth: _____

Mobile Number: _____

Email Address: _____

Emergency Contact Name: _____

Emergency Contact Phone Number: _____

SECTION 2: HEALTH & MEDICAL INFORMATION

Please answer honestly to ensure treatments are carried out safely.

Do you currently have any of the following?
(Tick all that apply)

- ☐ Diabetes
- ☐ Epilepsy
- ☐ Heart Condition
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Autoimmune Condition
- ☐ Cancer (current or previous)
- ☐ Thyroid Disorder
- ☐ Hormonal Imbalance
- ☐ Pregnancy
- ☐ Breastfeeding
- ☐ None of the Above

Are you currently taking any medication?

☐ Yes ☐ No

If yes, please list all medications:

_____

_____

_____

Do you have any allergies or sensitivities?

☐ Yes ☐ No

If yes, please provide details:

_____

_____

_____

Have you ever experienced a reaction to any skincare products, cosmetics, treatments, or ingredients?

☐ Yes ☐ No

If yes, please explain: _____

_____

Have you used any of the following in the last 6 months?
(Tick all that apply)

- ☐ Roaccutane / Isotretinoin
- ☐ Retinol / Retinoids
- ☐ Steroid Creams
- ☐ Prescription Acne Treatments
- ☐ Chemical Peels
- ☐ Laser Treatments
- ☐ None of the Above

Please provide details if applicable:

_____

_____

_____

Do you have any active skin conditions?
(Tick all that apply)

- ☐ Acne
- ☐ Rosacea
- ☐ Eczema
- ☐ Psoriasis
- ☐ Cold Sores
- ☐ None
- ☐ Other

Please provide details:

_____

_____

_____

SECTION 3: SKIN ASSESSMENT

How would you describe your skin type?

- ☐ Oily
- ☐ Dry
- ☐ Combination
- ☐ Normal
- ☐ Sensitive
- ☐ Unsure

What are your primary skin concerns?
(Select all that apply)

- ☐ Acne / Breakouts
- ☐ Pigmentation
- ☐ Fine Lines & Wrinkles
- ☐ Dehydration
- ☐ Sensitivity
- ☐ Redness
- ☐ Scarring
- ☐ Dull Skin
- ☐ Enlarged Pores
- ☐ Uneven Skin Tone
- ☐ Blackheads / Congestion
- ☐ Other _____

How sensitive is your skin?

- ☐ Very Sensitive
- ☐ Moderately Sensitive
- ☐ Slightly Sensitive
- ☐ Not Sensitive

Do you currently follow a skincare routine?

☐ Yes ☐ No

If yes, please list the products you currently use:

_____

_____

_____

How often do you wear SPF?

- ☐ Daily
- ☐ Most Days
- ☐ Occasionally
- ☐ Rarely
- ☐ Never

SECTION 4: TREATMENT GOALS

What would you like to achieve from your treatment?

_____

_____

Have you had professional facial or skin treatments before?

☐ Yes ☐ No

If yes, what treatments have you had?

_____

_____

Is there anything you would particularly like me to know before your appointment?

_____

_____

SECTION 5: CONSENT & DECLARATION

- ☐ I confirm that the information provided is accurate and complete to the best of my knowledge.
- ☐ I understand that withholding medical information may affect the safety and effectiveness of my treatment.
- ☐ I agree to inform my practitioner of any changes to my health or medication before treatment.

May I take before-and-after photographs for treatment records? ☐ Yes ☐ No

Signature: _____ Full Name: _____ Date: _____

All information is confidential and held securely in accordance with data protection regulations.

THANK YOU