LED LIGHT THERAPY CONSULTATION FORM

NAME: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

EMAIL ADDRESS: _____

DATE OF BIRTH: _____

EMERGENCY CONTACT: _____

This form is designed to help assess your skin type and your needs and expectations of the LED Light Therapy treatment.

1. Client skin type _____

	Skin type	Complexion	Description
•	Type 1	Very pale,	always burns, never tans
•	Type 2	Fair	skin and hair burns easily, tans minimally
•	Type 3	Slightly darker	skin burns sometimes, tans gradually
•	Type 4	Mediterranean;	burns rarely, tans easily
•	Type 5	Asian/Arabic:	burns rarely, always tans
•	Type 6	Afro-Caribbean;	never burns, always tans

2. Which skin care products do you use…

a. On The Face?_____

b. On The Neck? _____

c. Do you regularly use a face cream with an SPF? Y/N

3. Have you undergone any cosmetic/aesthetic treatments in the last 24 hours? Y/N

If YES please list _____

4. Are you currently undergoing any other aesthetic treatments? Y/N

If YES please list _____

5. Do you use sunbeds or are regularly exposed to sun? Y/N

6. Do you smoke? Y/N

7. What are your primary skin concerns?

_____

4. Are you currently undergoing any other aesthetic treatments? Y/N

If YES please list _____

8. What are your goals and expectations of the treatment?

_____

Treatment type:

- Anti-Ageing/Acne
- BlemishProne/Skin
- Post Treatment
- Other: _____