consultation **card**

prior to booking your **appointment**

To ensure safety for all, please complete this short questionnaire including questions about COVID-19 and your current health:

1 Have you tested positive for COVID-19, or been in contact with someone who has in the past 14 days? ☐ yes ☐ no

2 Have you been tested for COVID-19 and are currently awaiting the test results? ☐ yes ☐ no

3 Do you have any of the following flu like symptoms: fever, dry cough, body aches, headaches, sore throat, runny nose, shortness of breath? (Note: This refers to new or unusual symptoms not aligned with medical history. You may exclude known personal medical conditions that have the same symptoms, e.g. allergies, history of migraines.) ☐ yes ☐ no

4 Are you or your immediate contacts in a high-risk category? ☐ yes ☐ no

Please note, if you answered yes to any of the above questions, unfortunately we are unable to give you an in person treatment. Instead, we would like to offer a Mirror Me virtual service, where we can connect for a digital one on one consultation. Please provide a time and date where we can connect virtually.

dermalogica

skin therapist

name

address

city county postcode

email

phone

birthday

how did you hear about us?

Dermalogica takes privacy seriously. As the data controller of the personal data that you provide on this form, we will use your personal data for the purposes of carrying out your consultation and keeping a record of your treatments. Please refer to our full privacy policy on Dermalogica.co.uk for more information about your rights and how we use your personal data. If you have any questions, please use the Contact Us function at Dermalogica.co.uk.
I consent to the Dermalogica Group using my personal data to contact me using the methods set out below to advise me of new products, and to provide me with marketing and product information.

☐ SMS (text) ☐ phone ☐ post ☐ email

You can opt-out at any time by clicking on the unsubscribe link we provide in our communications or by using the Contact Us function at Dermalogica.co.uk.

your **health**

1 Within the last year, have you had any health problems that have affected or could affect your skin? ☐ yes ☐ no
If yes, please specify:

2 List any medications, supplements, vitamins, diuretics, slimming pills, oral contraceptives, Isotretinoin, etc. that you take regularly.

3 Do you wear contact lenses? ☐ yes ☐ no

4 Do you have metal implants, a pacemaker or body piercings? ☐ yes ☐ no

5 Do you have any allergies? ☐ yes ☐ no
If yes, please specify:

6 Do you have sinus problems? ☐ yes ☐ no

7 Have you ever experienced claustrophobia? ☐ yes ☐ no

your **skin**

8 What are your specific concerns/challenges with your skin?

9 What skin care products are you currently using?
☐ soap ☐ cleanser ☐ toner ☐ moisturiser
☐ masque ☐ exfoliant ☐ eye products ☐ other

10 Have you had chemical peels, microdermabrasion or any resurfacing treatments within the last three months? ☐ yes ☐ no

11 Have you:
Been waxed within the last 72 hours? ☐ yes ☐ no
Shaved within the last 24 hours ☐ yes ☐ no
If yes, please specify: ☐ wet ☐ dry

12 Have you used Retin-A, Renova, Adapalene or any other prescription skin products within the last three months? ☐ yes ☐ no

13 Are you currently using any products that contain the following ingredients? ☐ yes ☐ no

☐ Glycolic Acid ☐ Lactic Acid ☐ any exfoliating scrubs
☐ Other Hydroxy Acids ☐ Vitamin A derivatives (i.e., Retinol)

14 Please specify if any of the following apply to you:

☐ pregnant ☐ trying to become pregnant ☐ lactating ☐ menstruating ☐ pre-menstrual

15 Have you received a cosmetic light-based procedure such as laser treatment, IPL, etc. within the last 6 weeks? yes no

16 Do you have active cold sores? yes no

17 Have you received Botox or other injectable procedures within the past week? yes no

18 Do you sunbathe or use tanning beds? yes no

19 Do you experience redness, itching, or stinging on your skin? yes no

pro power peel **consent for treatment**

This treatment is designed to resurface the skin. You may experience temporary burning, itching, or stinging. Please inform your professional skin therapist if you experience these sensations.

Your full participation during and after the treatment will determine the outcome. It is important that you strictly adhere to the homecare products and regimen that your professional skin therapist has recommended. It is possible to have a poor reaction or less-than-expected improvement of the skin. No guarantee is made or implied as to the precise results, peeling times or discomfort.

I release Dermalogica (UK) Limited and _____, and their respective officers, directors, agents and employees, of and from any liability, claims, demands, actions and causes of action whatsoever arising out of or related to any loss, damage or injury that may be sustained by me while participating in the Pro Power Peel Treatment, including, but not limited to, those injuries and damages caused by breach of warranty, express or implied, excluding negligence or an act or omission that directly causes personal injury, on the part of Dermalogica and/or_____,

☐ Patch Test - Date_____ ☐ I have received Post-Care instructional sheet.

I confirm (to my best knowledge) that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment.

ProSkin ☐ Pro Power Peel ☐ _____
signature date

ProSkin ☐ Pro Power Peel ☐ _____
signature date

ProSkin ☐ Pro Power Peel ☐ _____
signature date

To be completed by skin therapist.

treatment / product record

date	skin therapist	notes
products		

date	skin therapist	notes
products		

treatment / product record

date	skin therapist	notes
products		

date	skin therapist	notes
products		