ARTISTRY® SKINCARE CONSULTATION

CLIENT DETAILS

FIRST NAME:	LAST NAME:	
ADDRESS:		
SUBURB:	STATE:	POSTCODE:
POSTAL ADDRESS (IF DIFFERENT FROM ADDRESS ABOVE)		
PHONE NUMBER:	MOBILE:	
EMAIL ADDRESS:		
IBO NUMBER:		
CONSULTANT NAME:	DATE:	

SKIN TYPE:

1. Does your skin tend to shine which is a sign of oiliness? ☐ Yes ☐ No						
2. Does your skin burn, itch or turn red? If Yes – diagnosed Skin Type is: **Sensitive**						
3. What time does your skin shine?	☐ Immediately	☐ Morning Tea	☐ Lunch	☐ Afternoon Tea	☐ Evening or Never	
Your diagnosed skin type is:	☐ Oily	☐ Normal / Combination	☐ Normal	☐ Normal-Dry	☐ Dry	Sensitive

SKIN CONCERNS:

4. Circle what areas concern you the most:					
☐ Wrinkles	☐ Firmness	☐ Premature Ageing	☐ Dryness	☐ Oil and Blemishes	☐ Dull & Uneven Skintone

5. Do you have blemishes? ☐ Yes ☐ No
6. Do you appear to have fine lines? ☐ Yes ☐ No
7. Does your skin have sun damage or pigmentation? ☐ Yes ☐ No
8. Do you suffer from puffiness or dark circles around the eyes? ☐ Yes ☐ No
9. Would you like to improve the texture and appearance of your skin? ☐ Yes ☐ No
10. Do you suffer from any allergies or skin conditions? ☐ Yes - Please specify _____
☐ No

ARTISTRY SKINCARE PRESCRIPTION:

ARTISTRY Products	Recommended Usage