



## BRIDAL BLISS BEAUTY PREPARATION CONSULTATION FORM

*The objective of the Bridal Beauty Planning Service is for us to work together to meet and achieve your bridal beauty goals. The more information I have about you will enable me to give you better advice and the best beauty recommendations*

Client Name: \_\_\_\_\_

Address: \_\_\_\_\_

Tel Mob: \_\_\_\_\_

Email: \_\_\_\_\_

Birthday: \_\_\_\_\_

Contact Number: \_\_\_\_\_

How did You Hear about VW: \_\_\_\_\_

### Wedding Details

Have you got your dress: \_\_\_\_\_

What style is your dress: Slimline, meringue, short:

What colour is your dress:

What is the date of wedding?

Are you getting married here or abroad?

Have you decided on your honeymoon, and if so where?

Will you be hosting your reception indoors or outside?

When was your last facial treatment?

Will you be wearing sandals or shoes on the day?

Have you found someone to do your make-up, or would you like me to recommend one for you?

Are you having bridesmaids? What are their ages?

What is your bridal beauty budget ?

Under £300

£300- £700

£700 +

Are there any parts of the face and body you are particularly concerned about?

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What is the best times available for you to have your treatments?

What work do you do, and hours worked?

**Your Health:**

Have you been under the care of a Dermatologist/Doctor in the last year? Y/N

If Yes: \_\_\_\_\_

Have you undergone any surgery within the last 9 months? Y/N

If Yes: \_\_\_\_\_

Any health problems past or present? Y/N

If Yes: \_\_\_\_\_

Are you currently taking any medication, supplements, vitamins, diuretics, slimming tablets? Y/N

Do you smoke? Yes ( ) Average per day \_\_\_\_\_ No ( )

Do you exercise regularly? Yes ( ) / No ( )

Do you wear contact lenses Yes ( ) / No ( )

Do you have metal implants, a pacemaker or body piercings? Yes ( ) / No ( )

How would you rate your general stress levels on a scale of 1 - 4, 1 being the lowest?

**Your Skin**

What skin care products are you currently using?

Face:  soap  cleanser  toner  moisturiser  masque  exfoliator  eye products

Body:  soap  shower gel  scrubs  oil  body moisturiser  depilatory products  self tanners

**Exfoliation History**

Have you ever had chemical peels, microdermabrasion, or any resurfacing treatments?

Yes ( ) / No ( ) in the last month Yes ( ) / No ( )

Do you use Accutane, Retin A, Renova, Adapalene

Yes ( ) / No ( ) in the last three month Yes ( ) / No ( )

Are you currently using any products that contain the following ingredients?

glycolic acid  lactic acid  any exfoliating scrubs  any hydroxyl acid product  vitamin A derivatives (i.e. retinol)

**Moisture Hydration**

Do you drink alcohol?

Yes ( ) Average daily consumption No ( )

\_\_\_\_\_

How many glasses of water do you drink daily? \_\_\_\_\_

Do you ever experience these conditions on your skin?  flakiness  tightness  obvious dryness

What spf sunscreen do you use on your face? \_\_\_\_\_ Body? \_\_\_\_\_

Do you sunbathe or use tanning beds? Yes ( ) / No ( )

Do you burn easily in moderate sunlight? Yes ( ) / No ( )

Do you blush easily when nervous? Yes ( ) / No ( )

Do you have a tendency to redness? Yes ( ) / No ( )

Do you suffer from sinus problems? Yes ( ) / No ( )

### **Oil Secretion**

Do you ever experience oily shine during the day?  yes  no  occasionally

Do you ever experience skin breakouts?  yes  no  occasionally

### **Nerve Activity**

Do you drink more than 4 caffeinated beverages daily? (coffee, tea, soft drinks)

Yes ( ) / No ( )

Do you ever experience a burning, itching sensation on your skin? Yes ( ) / No ( )

What is your pain threshold  low  medium  firm

Have you ever experienced claustrophobia? Yes ( ) / No ( )

Have you ever had a reaction to any of the following?

cosmetics  medicine  iodine  pollen  food  hydroxyl acids  animals  fragrance

sunscreens  other \_\_\_\_\_

Do you follow a restricted diet? Yes ( ) / No ( )

Would you be interested in more information on losing weight by a registered nutritionist?

Yes ( ) / No ( )

How would you describe your diet? \_\_\_\_\_

Breakfast	Lunch	Dinner	Time you eat by at night
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General immunity:	Good ( )	Average ( )	Poor ( )
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Energy levels:	High ( )	Medium ( )	Low ( )
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Stress levels:	High ( )	Medium ( )	Low ( )
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Sleep pattern:	Good ( )	Average ( )	Poor ( )
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Do you have any hobbies/time set aside for relaxation? Yes ( ) No ( )

Details: \_\_\_\_\_

Are you taking oral contraception? Yes ( ) / No ( )

Are you pregnant or trying to become pregnant? Yes ( ) / No ( )

Are you breastfeeding? Yes ( ) / No ( )

**Questions to discuss every visit**

Are you currently having or due for your menstrual period? Yes ( ) / No ( )

Have you started any new medication since your last visit? Yes ( ) / No ( )

Have you had any recent dental x-rays? Yes ( ) / No ( )

Do you have any other useful information for me to know:

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**Client's signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Therapist's signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_