

Full name	
Date	

# Environ

## CONSULTATION CARD



**ENVIRON®**  
a beautiful skin for a lifetime

Date of birth	
Occupation	
Contact number	
Email address	
May we contact you with information which may be of interest to you? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Referred by	
Emergency contact person	
Contact number	

### A 1 – About your skin:

1. What concerns you most about your skin? Please tick ☒

Ageing	Dehydration	Sensitivity	Pigmentation	Breakouts
<input type="checkbox"/> Sun damage <input type="checkbox"/> Wrinkles <input type="checkbox"/> Fine lines <input type="checkbox"/> Thin skin <input type="checkbox"/> Sagging skin	<input type="checkbox"/> Dry, flaky skin <input type="checkbox"/> Tight skin <input type="checkbox"/> Rough texture	<input type="checkbox"/> Redness <input type="checkbox"/> Rashes <input type="checkbox"/> Reactive skin <input type="checkbox"/> Dilated capillaries <input type="checkbox"/> Itchiness	<input type="checkbox"/> Dark pigmented marks <input type="checkbox"/> Lighter depigmented marks <input type="checkbox"/> Dark circles in the eye area	<input type="checkbox"/> Oily T-panel <input type="checkbox"/> Oily skin <input type="checkbox"/> Enlarged pores <input type="checkbox"/> Occasional breakouts <input type="checkbox"/> Severe breakouts <input type="checkbox"/> Uneven texture <input type="checkbox"/> Scarring

2. Any other concerns?

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### A 2 – About your skin:

1. What is your present skincare routine?

List the brand and specific products being used	
<input type="checkbox"/> Soap and water	
<input type="checkbox"/> Pre-cleanser	
<input type="checkbox"/> Cleanser	
<input type="checkbox"/> Exfoliator	
<input type="checkbox"/> Toner	
<input type="checkbox"/> Serum	
<input type="checkbox"/> Eye product	
<input type="checkbox"/> Moisturiser	
<input type="checkbox"/> Mask	
<input type="checkbox"/> Sunscreen	
<input type="checkbox"/> Other:	

### A 3 – About your skin:

1. Have you recently had any of the following aesthetic procedures?

Procedure	Treatment Area	Date
<input type="checkbox"/> Peels		
<input type="checkbox"/> Facial waxing		
<input type="checkbox"/> Botulinum toxin		
<input type="checkbox"/> Fillers		
<input type="checkbox"/> Microdermabrasion		
<input type="checkbox"/> Laser resurfacing		
<input type="checkbox"/> Cosmetic surgery		
<input type="checkbox"/> Laser hair removal		
<input type="checkbox"/> IPL		
<input type="checkbox"/> Microblading		
<input type="checkbox"/> None of the above		
<input type="checkbox"/> Other:		

## A 4 – About your skin:

1. Have you ever been treated with any of the following?

Treatment	Date
<input type="checkbox"/> Cis-retinoic acid (Roaccutane®)	
<input type="checkbox"/> Retin A®, Differin® Gel, Adapalene, Tretinoin, etc.	
<input type="checkbox"/> Topical antibiotics	
<input type="checkbox"/> Anti-fungal nail treatments	
<input type="checkbox"/> Topical cortisone	
<input type="checkbox"/> Benzoyl peroxide	
<input type="checkbox"/> Salicylic acid	
<input type="checkbox"/> Alpha hydroxy acids	
<input type="checkbox"/> Hydroquinone	
<input type="checkbox"/> None of the above	
<input type="checkbox"/> Other:	

## C 1 – Medical profile:

1. Do you suffer from any of the following? **Please tick** ☒

- ☐ Fever blisters
- ☐ Sinusitis
- ☐ Allergies e.g. Aspirin®: \_\_\_\_\_
- ☐ Food intolerances
- ☐ Claustrophobia
- ☐ Cardiac irregularities
- ☐ Diabetes Type 1/2
- ☐ High cholesterol
- ☐ High/low blood pressure
- ☐ Thyroid condition
- ☐ Epilepsy
- ☐ Lupus
- ☐ None of the above
- ☐ Other: \_\_\_\_\_

2. Do you suffer from any of the following skin disorders? **Please tick** ☒

- ☐ Psoriasis
- ☐ Eczema
- ☐ Keloid scarring
- ☐ None of the above
- ☐ Other: \_\_\_\_\_

3. Do you have a pacemaker? ☐ Yes ☐ No

4. Do you have metal implants? ☐ Yes ☐ No

5. Do you have braces? ☐ Yes ☐ No

6. Do you wear contact lenses? ☐ Yes ☐ No

7. Are you currently taking any of the following? (Please specify)

☐ Medication: \_\_\_\_\_

☐ Nutritional supplements: \_\_\_\_\_

## B 1 – Lifestyle:

1. General health: **Please tick** ☒

#	Question	Response
1.	Do you smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Are you on a specific diet?	
3.	Stress level	<input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High
4.	Regular exercise	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	How many glasses of water do you drink per day?	
6.	Sun exposure	<input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High

## D 1 – Female clients:

1. **Please tick** ☒

☐ Hormonal imbalance (polycystic ovarian syndrome, endometriosis, etc.): \_\_\_\_\_

☐ Contraceptive: \_\_\_\_\_

☐ Hormone replacement therapy: \_\_\_\_\_

☐ Are you pregnant? ☐ Yes ☐ No

☐ Are you lactating? ☐ Yes ☐ No

☐ Are you planning pregnancy? ☐ Yes ☐ No

## E 1 – Male clients:

1. **Please tick** ☒

Shaving method: \_\_\_\_\_

Irritation from shaving? ☐ Yes ☐ No

### Step 2: Client permission

#### Possible effects associated with Electro-Sonic DF Machine treatments

1. You might experience any of the following during treatment:
- Slight flashing over the eyes.
  - Tingling sensation in the area that the passive electrode is placed.
  - Tingling sensation on the skin.
  - A possible high-pitched sound when the sonophoresis probe is applied close to the ears and/or forehead.
  - A slight metal taste in the mouth if you have excessive metal fillings or braces.
2. You might experience the following post treatment:
- Temporary redness, which will subside soon after the treatment.
  - You could experience a retinoid reaction (flaking, dryness, skin sensitivity or slight breakouts), but this is due to the enhanced penetration of the active ingredients into the skin.

#### Possible effects associated with an Environ Cool Peel® treatment

1. You might experience a slight tingling sensation during the cool peel treatment.

2. Post peel treatment, the skin will become dry and possibly flake for up to 10 days.
3. The skin will be more sensitive to UV irradiation after a cool peel treatment and therefore requires sun protection.

**Please notify your skincare professional if you experience any discomfort during your treatment, including stinging and burning.**

**Please sign by clicking on the box below. Alternatively, if the Card has been printed, please sign in the field provided.**

Client signature: ☐ \_\_\_\_\_  
(parent/guardian if applicable)

Skincare professional signature: ☐ \_\_\_\_\_

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

Step 3: To be completed by the skincare professional

Name

A 1 – Skin analysis:

1. Photo type: Please tick

☒

- i. ☐
- ii. ☐
- iii. ☐
- iv. ☐
- v. ☐
- vi. ☐

2. Skin texture:

- ☐ Fine
- ☐ Medium
- ☐ Rough
- ☐ Combination

3. Skin elasticity:

- ☐ Normal – good elasticity
- ☐ Mild damage – early sun damage
- ☐ Poor – moderate sun damage
- ☐ Very poor – severe sun damage

4. Skin condition: Please tick

☒

Skin condition	Ageing					Dehydration			Sensitivity			Pigmentation		Blemish-prone				
	Thin texture	Fine lines and wrinkles	Laxity	Keratosis	Elastosis	Flaking	Water dry	Oil dry	Redness/ Rashes	Rosacea	Compromised barrier	Hyper-pigmentation	Hypo-pigmentation	Comedones	Papules	Inflamed Pustules	Scarring	Hormonal breakouts
Forehead																		
Between brows																		
Eye area																		
Nose																		
Cheeks																		
Lip area																		
Chin																		
Jaw line																		
Neck																		
Décolleté																		
Total:	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

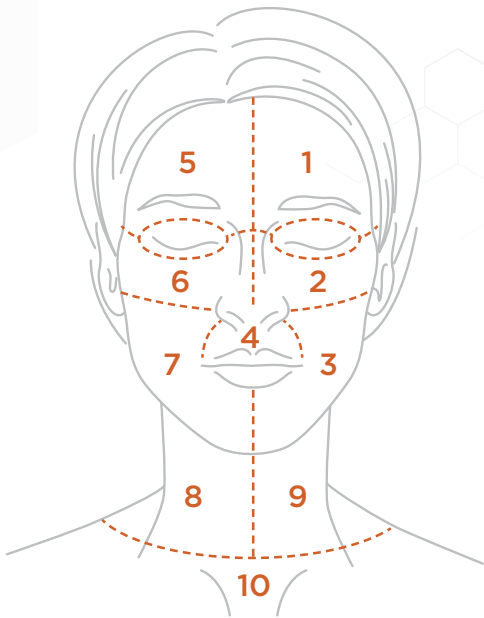
Additional notes:

5. Date of photographs:

Before:

Intermediate:

After:



Step 4: To be discussed with the client

B 1 – Treatment plan:

1. Overall objective:

2. Home-care routine recommendation. Environ Skin Care Prescription<sup>3</sup> method:

Step	AM	PM
Step 1: Essential Care		
Skin preparation Normalise the skin type with vitamin A		
Step 2: Focused Care		
Target specific skin conditions by adding Focus Care™		
Step 3: Even More Care		
Protect and enhance with Even More		

3. Professional treatment plan – overall objective:

- ☐ Essential Treatments:
- ☐ Focus-On Treatments:
- ☐ Cool Peel Treatments:

4. Treatment record: to complete after each treatment

	Date	Treatment Name	Treatment Serum(s)	Samples Given	Notes
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					