

SOTHYS CONSULTATION CARD

CLIENT QUESTIONNAIRE



Client name: Mr/Mrs/Ms/ _____
(Christian name) (Surname)

Address: _____
Postcode: _____

Telephone: (h) _____ (w) _____

Birthdate: _____ Occupation: _____
(Day) (Month) (Year)

How were you referred? _____

HEALTH

1. Do you suffer from any allergies?

Yes No

If yes to what? _____

2. Do you wear contact lenses?

Yes No

3. Please list vitamins/medications (including hormones) that you take regularly

4. Are you pregnant or trying to become pregnant?

Yes No

5. Have you had any surgery in the last 6 months?

Yes No

6. Have you had any of these health problems past or present

- Diabetes
- Cancer
- Epilepsy
- Hysterectomy
- Hormone imbalance
- Heart problems
- Varicose veins
- High blood pressure
- Respiratory problems (asthma etc.)
- Metal implants
- Thyroid
- Other _____

LIFESTYLE

7. Are you on a restricted diet?

Yes No

8. Do you exercise regularly?

Yes No

9. Do you get an adequate amount of sleep?

Yes No

10. Do you drink alcohol?

Yes No

11. Do you smoke?

Yes No

12. On average, how many cups of tea or coffee would you consume daily?

13. How many glasses of water would you consume daily?

Less than 8 8 or more

IN SALON TREATMENTS

14. Have you visited this salon before?

Yes No

15. Have you visited another salon?

Yes No

16. Please describe the experience

Poor Good Excellent

17. How long ago was your last visit?

1 month 2 or more months

18. Do you prefer a firm or light massage?

Firm Light

19. Are you happy with the hydration/tono of you body?

Yes No

20. Would you like information on our body treatment line?

Yes No

GENERAL QUESTIONS

21. Would you like to receive our newsletter?

Yes No

22. Would you like to be notified about any special events/promotions that we are holding?

Yes No

The answers I have given are true and correct to the best of my knowledge.

Client signature

OFFICE USE ONLY

