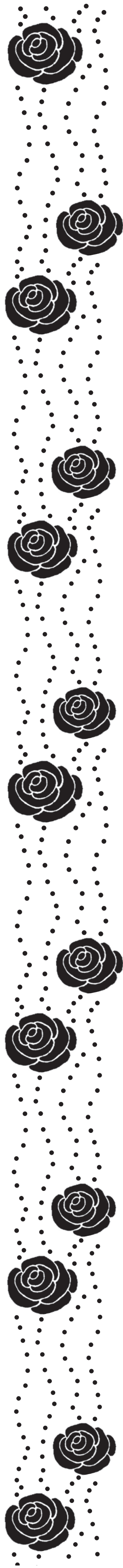


Divine Rose

• Wholistic Organic Facials •

Cori Roth
Licensed Esthetician (NC #E3914)
& Dr. Hauschka Esthetician
By Appointment Only
919.933.4748
DivineRose55@gmail.com

The following information is necessary to evaluate and meet your individual needs for professional service and home care maintenance. All information is confidential.

Name______________________________________ Date________________

Date of Birth______________________ Phone__________________________

Address ____

Occupation ____

Interests____

Consultation Questions

What are three improvements you would like to see in your skin?

1. ____
2. ____
3. ____

How much time are you willing to devote to your skin? AM_________ PM _________

What products are you currently using? (cleanser, toner, moisturizer)________________

____

What area of the face and/or neck do you feel needs the most attention today? ____________

Have you used an Alpha Hydroxy, Beta Hydroxy, Glycolic Acid, Retin-A, or any other deep exfoliation in the past week? ❑ Yes ❑ No

Are you currently taking any topical or oral medications and/or supplements? *(ie herbs, pharmaceuticals, prescription, nonprescription, Bach flowers, homeopathic remedies)* ❑ Yes ❑ No

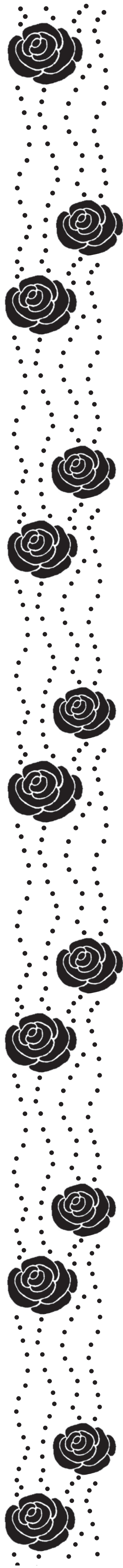
If yes, please list____

Are you currently undergoing cancer treatment? ❑ Yes ❑ No

Thyroid Health: ❑ Normal ❑ Abnormal

Active case of acne: ❑ Yes ❑ No

Allergies: ❑ Yes ❑ No If yes, please list ___________________________



Name ____

If you were to choose one or two emotions that seem predominant in your life they would be

____

Essential oil/fragrance preferences? (ie Lavender, Rose, Lemon, Sage...) ____________________

Common physical activities: Please check those activities which you feel you are involved in on a regular or daily basis. Comment below.

- ❑ Desk Sitting (How long?____________)
- ❑ Sitting in a Car (How long?____________)
- ❑ Standing (How long?____________)
- ❑ Calisthenics
- ❑ Aerobics
- ❑ Swimming
- ❑ Jogging/Running
- ❑ Hiking
- ❑ Bike Riding
- ❑ Horseback Riding
- ❑ Tennis
- ❑ Weight Lifting
- ❑ Walking
- ❑ Tai Chi
- ❑ Yoga
- ❑ Dancing

Please explain dietary preference *(ie vegetarian, lacto-vegetarian, meat, fish, dairy, macro-biotic,etc.)*

____

____

____

Dietary Habits: Please check each item below if included in your usual diet.

- ❑ Red Meat
- ❑ Fish
- ❑ Poultry
- ❑ Fruits
- ❑ Vegetables
- ❑ Leafy Greens
- ❑ Raw Foods
- ❑ Seaweed
- ❑ Nuts
- ❑ Grains
- ❑ Butter
- ❑ Milk
- ❑ Cheese
- ❑ Yogurt
- ❑ Fermented Foods
- ❑ Food Supplements
- ❑ Protein Supplements
- ❑ Vitamins
- ❑ Sugar
- ❑ Honey
- ❑ Baked Goods
- ❑ Desserts
- ❑ Seeds
- ❑ Coffee
- ❑ Black Tea
- ❑ Herbal Tea
- ❑ Alcohol
- ❑ Smoked Cigarettes

Payment: Cash or Check Only

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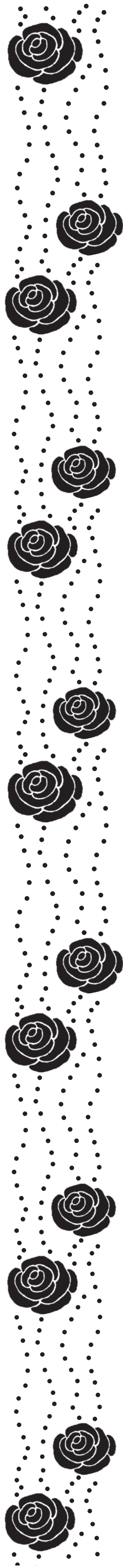

Name ______________________________

Temperament Questionnaire

Please complete the following form by circling the description that most accurately describes what you are experiencing today!

Today	Sanguine/Air	Choleric/Fire	Phlegmatic/ Melancholic Water/Earth
My skin feels	dry & dehydrated	sensitive & irritated	oily & congestive
My main concern about my skin is:	fine lines & signs of aging	pigmentation & sensitivity	acne, breakouts & congestion
My energy level is:	high (active)	moderate (consistent)	low (sluggish)
My stress level is:	high	moderate / balanced	low
My overall body temperature feels:	moderate to cool	warm to hot	cold with poor circulation
My body feels:	light & graceful	strong & firm	heavy & sluggish
My main area of tension is:	head, neck, & shoulders	torso & back	low back & legs
Today			

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