

SKINCARE CONSULTATIONS

Get personalized skin coaching
from a Facial Bungalow esthetician

NAME: _____

DATE: _____

How did you hear about Trina Renea Skincare (TRS)? *(Check all that apply)*

- | | | |
|--|---|-----------------------------------|
| <input type="radio"/> Repeat Customer | <input type="radio"/> Received A Gift Certificate | <input type="radio"/> TV |
| <input type="radio"/> Friend: _____ | <input type="radio"/> Internet | <input type="radio"/> Other _____ |
| <input type="radio"/> Driving/Walking By | <input type="radio"/> Twitter | |
| <input type="radio"/> Magazine | <input type="radio"/> Facebook | |

Do you have a gift certificate? Circle: YES or NO _____

If yes, how much and what is it for?

Have you purchased products from TRS before? Circle: YES or NO

Your age: _____ Gender: Male or Female Your birthday (MM/DD/YYYY): _____

We'll send you a special birthday gift!

Email Address: _____

Best Contact Phone Number: _____ Circle One: CELL HOME WORK

Alternative Phone Number: _____ Circle One: CELL HOME WORK

Mailing Address: _____
STREET CITY STATE ZIP

What are your skin concerns? *(Check All That Apply:)*

- | | |
|--|--|
| <input type="radio"/> Acne and Blemishes | <input type="radio"/> Dehydration (feels tight) |
| <input type="radio"/> Oiliness | <input type="radio"/> Dryness (feels tight and is flaky) |
| <input type="radio"/> Brown/Sun Spots | <input type="radio"/> Lines and Wrinkles |
| <input type="radio"/> Clogged Pores/Blackheads | <input type="radio"/> Large Pores |
| <input type="radio"/> Loss of Tone/Lack of Firmness | <input type="radio"/> Age Prevention/ Keeping skin healthy |
| <input type="radio"/> Redness/Sensitivity | <input type="radio"/> Other: _____ |
| <input type="radio"/> Rosacea | <input type="radio"/> No Other Concern |
| <input type="radio"/> Easily irritated by products/Sensitive | |

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Do you have any of these issues? *(Check all that apply)*

- Under Eye Puffiness
- Broken Capillaries
- Other: _____
- Dark Circles
- Milia (hard white bumps on the skin,
commonly found around the eyes)

How Oily or Dry is Your Skin? *(Check One)*

- Oily year round
- Normal year round
- Combination year round
- Combination in the summer,
normal in the winter
- Oily in the summer,
combination in the winter
- Dry year round
- Combination (t-zone oil)
yearround
- Normal in the summer, dry in
the winter

How often do you get blemishes? *(Check One)*

- Never (this is not an issue for me)
- Occasionally (a few a month)
- Daily (a new blemish appears
every day)
- Rarely (once in a while)
- Often (approximately one per week)
- Often (approximately 2-3
breakouts per week)
- Occasionally (once a month
or less)

What type of blemishes do you get most often? *(Check all that apply)*

- Cysts (hard, sore "underground" blemishes under the skin that rarely surface)
- Pustules (red, inflamed, traditional "zits" that usually surface)
- Whiteheads/Closed Comedones (non-sore, clogged bumps under the skin)
- Other: _____

Where do you get the majority of your blemishes? *(Check One)*

- Forehead
- Cheeks
- Chin/Jaw Line/Neck
- Nose
- Back
- Other: _____

What is your skin tone? *(Check One)*

- Very Fair
- Medium
- Dark
- Fair
- Medium-Olive
- Very Dark

How often do you wear sunscreen on your face? *(Check One)*

- 365 days a year
- Only in the spring/summer | Only when outdoors
- Other: _____

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How often do you get facials, peels or other skin care treatments? *(Check One)*

- Monthly
- Every other month
- Every change of season
- When I receive a gift certificate
- Special occasions (birthday, wedding, class reunions, etc.)
- When I think my skin needs it
- When I want to be pampered/relaxed
- When I'm in town visiting
- Other: _____

Do you get any of these professional treatments? *(Check All That Apply)*

- Chemical Peels, *how often?* _____
- Laser Treatments, *how often?* _____
- Injectable Fillers, *how often?* _____
- Other _____

Are you using any topical prescription treatments on your skin? *If so, describe...*

Do you have any skin allergies or is there anything else you would like us to know?

When it comes to caring for your skin at home, which statement best describes you? *(Check One)*

- I barely use anything on my skin
- I use cleanser and moisturizer
- I use cleanser, toner and moisturizer
- I use cleanser, toner and moisturizer and occasionally will add in an extra product or two. (For example, mask, serum, scrub, peel or eye cream)
- I use a full routine, complete with serums, masks and eye cream

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What skin care products do you use at home? *(Brand names if you can provide them)*

Daytime

Cleanser: _____

Toner: _____

Moisturizer: _____

Other: _____

Evening

Cleanser: _____

Toner: _____

Moisturizer: _____

Other: _____

Do you smoke? *(Check One)*

- No Occasionally Yes

Do you prefer extractions when you have a professional facial? *(Check One)*

- Yes, my skin needs a lot of extractions
 Yes, but only if my skin needs it
 No, I prefer not to have extractions