

Skin Care Analysis

Date _____

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Best Time to Call _____

Email _____

Describe Your Skin _____

Concerns & Interests

- | | | |
|---|---|--|
| <input type="checkbox"/> Fine lines & wrinkles | <input type="checkbox"/> Sensitive Skin | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Occasional Blemishes | <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> Vitamins |
| <input type="checkbox"/> Dark Under Eye Circles | <input type="checkbox"/> Sun Damage | <input type="checkbox"/> Currently Dieting |
| <input type="checkbox"/> Blackheads/Whiteheads | <input type="checkbox"/> Oily T-Zone Area | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Redness | <input type="checkbox"/> Ingredients | _____ |

What skin products do you currently use? _____

If you had a magic wand, what would you change about your skin or health?

Have you ever used products that incorporate:

Vitamin C Therapy _____ Alpha Lipoic Acid _____

What are you using to support and repair collagen? _____

Are you currently taking a skin care supplement? _____

Do you use sunscreen? ____ How much time do you spend in the sun? _____

Do you feel you drink enough water (8 glasses a day)? _____

Do you read the ingredients that are in your makeup line? _____

Do you remove your makeup before going to sleep? _____

Are you having any specific problems or conditions? _____

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