	YES	NO
ARE YOU ON ANY MEDICATION?	☐	☐
HAVE YOU ANY ALLERGIES?	☐	☐
HAVE YOU ANY OPEN CUTS/WOUNDS/RASHES?	☐	☐
DO YOU SUFFER FROM ANY SKIN DISORDERS?	☐	☐
DO YOU HAVE ANY SKIN PIGMENTATION DISORDERS?	☐	☐
IS YOUR SKIN HYPERSENSITIVE?	☐	☐
DO YOU SUFFER FROM ANY RESPIRATORY PROBLEMS?	☐	☐
DO YOU SUFFER FROM DRY SKIN AT ALL?	☐	☐
ARE YOU PREGNANT OR BREAST FEEDING?	☐	☐
HAVE YOU RECENTLY HAD BODY PIERCING/TATTOOS?	☐	☐
HAVE YOU USED SELF-TANNING PRODUCTS BEFORE?	☐	☐
HAVE YOU USED SELF-TANNING PRODUCTS IN THE LAST 7 DAYS?	☐	☐
HAVE YOU HAD A SPRAY TAN BEFORE?	☐	☐
DO YOU WEAR CONTACT LENSES?	☐	☐
HAVE YOU HAD RECENT BOTOX/FILLERS?	☐	☐
IS THE TAN FOR A SPECIAL OCCASION?	☐	☐
DID YOU EXFOLIATE? WHEN _____	☐	☐
HAVE YOU APPLIED MOISTURISER TODAY?	☐	☐
DO YOU HAVE BLEACHED HAIR?	☐	☐
HAVE YOU GOT LOOSE DARK CLOTHING FOR AFTER YOUR TREATMENT?	☐	☐

PRODUCT RECOMMENDATIONS

- ☐ MEDIUM DARK
- ☐ DOUBLE DARK
- ☐ ULTRA DARK
- ☐ CARAMEL
- ☐ OLIVE
- ☐ VIOLET
- ☐ DARK ASH
- ☐ PERFECT BRIDE
- ☐ WONDERTAN
- ☐ COCONUT WATER
- ☐ WORKOUT READY
- ☐ MOROCCAN
- ☐ ABSOLUTE

COMMENTS

_____

FOR OFFICE USE ONLY

THERAPIST SIGNATURE

DATE / /

CONSULTATION CARD

CLIENTS NAME

DATE OF BIRTH

ADDRESS 1

ADDRESS 2

STATE POSTCODE

EMAIL

PHONE NUMBER

INDEMNITY. I DECLARE THAT I HAVE READ AND UNDERSTOOD THE QUESTIONS ABOVE LEFT, WHICH ARE CORRECT, AND I HAVE NO MEDICAL CONDITIONS THAT MAY AFFECT OR INDUCE A HARMFUL REACTION FROM SPRAY TANNING SOLUTION.

SIGNATURE

DATE

/ /

mine®
TAN.BODY.SKIN

DATE	TREATMENT	THERAPIST