▼ **TABLE 12–6** The Client Questionnaire

Confidential Makeup Questionnaire

PLEASE PRINT Today's Date: _____

First Name: _____ Last Name: _____ Birthday _____/_____

Street _____ Apt# ___---_____ City _____ State _____ Zip _____

Phone: Home ( ) _____ Work ( ) _____ Cell ( ) _____ E-mail: _____

Referred by (circle one): Friend Social Media Walk-by Gift Certificate Browser Search Other:_____

- Have you ever had a professional makeover ☐ Yes ☐ No
- If yes, what did you like (dislike) about the session?

  _____
- What are some of your goals today?

  _____
- What special areas would you like to focus on?

  _____
- What are your favorite makeup and clothing colors?

  _____
- Describe an ideal look for your makeup.

  _____
- Do you wear contact lenses? ☐ Yes ☐ No If yes, are they: ☐ Hard ☐ Soft
- Do you take any medications that cause your eyes to be dry or itch? ☐ Yes ☐ No
  If yes, what? _____
- Are you currently taking prescription drugs that affect your skin or have you taken any in the past? ☐ Yes ☐ No
  If yes, describe the course and length of treatment. _____
- Do you have any health condition that may cause sensitivity in your skin or eye area? ☐ Yes ☐ No
  If yes, what? _____
- Do you have any allergies? ☐ Yes ☐ No If yes, please indicate. _____
- Do you have any allergies to skin care products? ☐ Yes ☐ No If yes, what? _____

I fully acknowledge that I do not have any known allergies to makeup products, or contagious conditions, or have listed them above.

Signature: _____

Salon Policies

(Note: This is just an example of policies that may be used.)

1. We require a 24-hour cancellation notice.
2. Please arrive on time for appointments.
3. There is a $25 charge for a no-show appointment.
4. Health regulations do not allow us to accept returned products unless they are unopened and in their original packaging.
5. Returns are given salon credit only. No cash refunds.

I fully understand and agree to the above salon policies.

Client's Signature: _____ Date: _____