

Personal Health & Skin Care Consultation

My favorite....

Name: _____ Spouse/Significant Other: _____

Address: _____

City: _____ Zip: _____ Email: _____

Home Phone: _____ Cell Phone: _____

Best Time to call: _____ Birthday: _____

Skin Type: DRY NORMAL COMBINATION OILY ACNE

My skin concerns are: (check ALL that apply)

- Sensitive skin
- White heads
- Occasional blemishes
- Crows feet
- Dark under eye circles
- No time for skin care
- Fine lines and wrinkles
- Large pores
- Black heads
- Makeup doesn't last
- Sun damage
- Lines around mouth

My Health concerns are: (check ALL that apply)

- Weight Management
- Poor energy level
- PMS
- Menopause
- Constipation
- Skip meals/eat on the run
- Joint Pain/Arthritis
- Hot flashes
- Aching Back/neck
- Would like info on:**
- Earning extra income
- Working from home
- Earn a FREE vacation
- Earn a Mercedes Benz
- Financial Freedom

- Interests**
- Skin Care Cosmetics
 - Hair Care Body Care
 - Nutritional Supplements
 - Baby Care Aromatherapy
 - Specials Product Savings Business

Who do you know?

Your interest

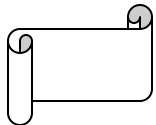
1 2 3

I currently cleanse and moisturize with _____

What supplements are you currently taking? _____

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

Wish List



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