

BEAUTY BASICS SURVEY AN APPROACH TO BEAUTY INSIDE AND OUT

What is the No. 1 reason you came today? _____

Do you currently wear cosmetics? Yes _____ No _____

Do you currently use skincare products? Yes _____ No _____

What is the ONE makeup product you could not live without? _____

What is your favorite cosmetic product? _____

Please explain why (results, brand loyalty, price, etc.). _____

Do you have any sensitivity to fragrance or certain ingredients? If so, what? _____

How do you apply your makeup at home? _____

How many beauty products do you use daily (cosmetics)? _____

Do you shop online for beauty products? Yes _____ No _____

If so, where? _____

Do you or someone you know have issues or concerns with the following?

Complete for a FREE gift!

Check the following that fit	You	Name of family member or friend
Makeup does not go on smoothly/evenly	_____	_____
Eye makeup creases and does not last	_____	_____
Makeup does not stay on or look fresh	_____	_____
Interested in a custom-blended foundation/powder	_____	_____
Skin is oily/dry	_____	_____
Interested in reversing/repairing aging	_____	_____
Skin has uneven tone and texture	_____	_____
Interested in repairing lines, dryness and darkness around eyes	_____	_____
Interested in hosting an Event	_____	_____
Digestive health (acid reflux, ulcers, IBS, colitis, etc.)	_____	_____
Interested in slowing down the aging process from the inside	_____	_____
Interested in learning more about wellness and nutrition	_____	_____

Name of who invited you _____

Your name _____

Address _____

City _____ State _____ ZIP _____

Phone No. _____ Email _____