



To help understand your skin type and decide which products to use for daily skin care, please take time off to complete this questionnaire.

Name: \_\_\_\_\_ Gender:  Male  Female  
 Email: \_\_\_\_\_ Contact no: \_\_\_\_\_  
 Address: \_\_\_\_\_ Date: \_\_\_\_\_

**Determine your skin type** Tick (✓) inside where appropriate

|   | A   | B   | C   |
|---|---|---|---|
| After washing your face, your skin feels                      | <input type="checkbox"/> Oily again very fast     | <input type="checkbox"/> Soft & comfortable             | <input type="checkbox"/> tightened                                  |
| Your skin texture belongs to                                  | <input type="checkbox"/> Rough                    | <input type="checkbox"/> Fine                           | <input type="checkbox"/> Visible wrinkles                           |
| Does your skin show signs of oiliness easily?                 | <input type="checkbox"/> Very oily                | <input type="checkbox"/> Partial oily                   | <input type="checkbox"/> Not Oily                                   |
| How often does your skin have blackheads and pimple breakout? | <input type="checkbox"/> Very Often               | <input type="checkbox"/> Occasionally                   | <input type="checkbox"/> Rarely                                     |
| Pigmentation on your skin                                     | <input type="checkbox"/> Not bad                  | <input type="checkbox"/> On both cheeks (or some areas) | <input type="checkbox"/> All over the face                          |
| Elasticity of your skin                                       | <input type="checkbox"/> Very good                | <input type="checkbox"/> Normal                         | <input type="checkbox"/> Very loose                                 |
| Colour tone or skin tone of your face                         | <input type="checkbox"/> Red w acne scars         | <input type="checkbox"/> Even                           | <input type="checkbox"/> Dull/ with some sensitive red pigmentation |
| Open pores on your skin are                                   | <input type="checkbox"/> Very big (on most areas) | <input type="checkbox"/> Partially (T-zone)             | <input type="checkbox"/> Only on some areas                         |

Your skin belongs to: Tick (✓) where appropriate

- A** Oily & prone to pimples/ blackheads
- B** Combination, easily dehydrated
- C** Dry/ sensitive and matured skin

**Do you**

- Visit a beauty salon
- Do your own facial at home



**Determine your common skin problems** Tick (✓) inside box where appropriate

|  | Very Often | Sometimes | Never |
|--|------------|-----------|-------|
| Are you prone to acne and blackheads when you are under stress or during menstruation? |            |           |       |
| Is your skin sensitive to new skin care or beauty products?                            |            |           |       |
| Are you allergy to any particular foods or objects?                                    |            |           |       |
| Does your skin show sign of discomfort when there is a change in weather?              |            |           |       |

**Identify the problems on your face** Tick (✓) where appropriate

Lines at eye area

Freckles

Acne/ pimples

Blackheads

Dark eye circle/ eye bag



Dry lines

Sensitive skin

Oily T-zone

Open pores

Yellow skin/  
dull

**Products you currently use** Tick (✓) where appropriate

Lotion Cleanser / Gel Cleanser

Night cream

Clarifying Mask

Body lotion

Toner

Eye Cream

Exfoliating scrub

Others: \_\_\_\_\_

Moisturizer

Eye Gel

Moisture Mask

**Improvements you like to achieve on your skin**

---



---



---



## Rate NouriFusion products

Product range used:  Normal to Dry OR  Normal to Oily (Tick (✓) where appropriate)

|                                 | Texture & Fragrance |      |           | Price rating |            | Packaging |      | Rate Best Product |
|---------------------------------|---------------------|------|-----------|--------------|------------|-----------|------|-------------------|
|                                 | Normal              | Good | Very Good | Expensive    | Reasonable | Normal    | Good |                   |
| Lotion Cleanser (Normal to Dry) |                     |      |           |              |            |           |      |                   |
| Cleanser Gel (Normal to Oily)   |                     |      |           |              |            |           |      |                   |
| Toner                           |                     |      |           |              |            |           |      |                   |
| Moisturizer SPF 15              |                     |      |           |              |            |           |      |                   |
| Exfoliating Scrub               |                     |      |           |              |            |           |      |                   |
| Clarifying Mask                 |                     |      |           |              |            |           |      |                   |
| Moisture Mask                   |                     |      |           |              |            |           |      |                   |
| Night Crème                     |                     |      |           |              |            |           |      |                   |
| Eye Crème                       |                     |      |           |              |            |           |      |                   |
| Eye Gel                         |                     |      |           |              |            |           |      |                   |

## Make a list of your friends who can benefit from the skin care demo

|    | Name | Relationship | Contact No. | Notes |
|----|------|--------------|-------------|-------|
| 1  |      |              |             |       |
| 2  |      |              |             |       |
| 3  |      |              |             |       |
| 4  |      |              |             |       |
| 5  |      |              |             |       |
| 6  |      |              |             |       |
| 7  |      |              |             |       |
| 8  |      |              |             |       |
| 9  |      |              |             |       |
| 10 |      |              |             |       |

## What other information would you be interested in?

Skin care products

Weight management

Business Opportunity



## Health Questions

Your current weight: \_\_\_\_\_ Your Ideal weight: \_\_\_\_\_

How often do you exercise?

- Daily
  Weekly
  Hardly

Do you have any of these illnesses before?

- Migraine
  Gastric
  Heart problem  
 Constipation
  Water retention
  Insomnia  
 Diabetic
  Hypertension
  Anemia

Which of the following methods have you ever tried to keep fit?

- Starvation
  Exercise
  See doctor  
 Use of slimming cream
  Medication
  Beauty salon  
 Replacement meal
  Others: \_\_\_\_\_

Which of the following area do you wish to reduce?

- Face
  Arms
  Back muscles  
 Waist
  Tummy
  Hips  
 Thigh
  Calves

What is the most important issue you would consider when choosing the methods of reducing weight?

- Healthy/ Safety
  Effective results
  Fast results

Do you or your relatives/ friends wish to improve on any of the following health issues?

|    |  | Myself (✓) | Names of Friends/ Relatives |
|----|--|------------|-----------------------------|
| 1  | Weight Gain                                |            |                             |
| 2  | Weight Loss                                |            |                             |
| 3  | Migraine                                   |            |                             |
| 4  | Insomnia                                   |            |                             |
| 5  | Sinus                                      |            |                             |
| 6  | Sensitive Skin                             |            |                             |
| 7  | Improve diabetic condition                 |            |                             |
| 8  | Improve heart problems/ cholesterol level  |            |                             |
| 9  | Improve level of immunity                  |            |                             |
| 10 | Improve digestive system/ gastric problems |            |                             |
| 11 | Improve female hormone balance             |            |                             |
| 12 | Others: _____                              |            |                             |