CONSULTATION FORM FOR AESTHETIC TREATMENTS

PLEASE TAKE THE TIME TO READ THIS FORM CAREFULLY AND TO UNDERSTAND ANY ACCOMPANYING INFORMATION IF APPLICABLE.

PLEASE ANSWER ALL OF THE QUESTIONS BELOW TO THE BEST OF YOUR KNOWLEDGE

|  |
| --- |
| FULL NAME: |
| D.O.B: |
| ADDRESS: |
| MOBILE TEL NUMBER: |
| HOME TEL NUMBER: |
| EMAIL ADDRESS: |
| DOCTORS NAME: |
| DOCTORS ADDRESS: |
| DOCTORS TEL NUMBER: |

|  |  |  |
| --- | --- | --- |
| PLEASE TICK THE APPROPRIATE BOX | YES | NO |
| DO YOU HAVE ANY CURRENT OR CHRONIC MEDICAL ILLNESSES I SHOULD BE AWARE OF? IF YES, PLEASE STATE BELOW  (FOR EXAMPLE- THYROID, HEART CONDITIONS, CANCER, CANCER WITHIN YOUR FAMILY, EPILEPSY, DIABETES) |  |  |
| DO YOU SUFFER WITH DIABETES? IF YES, IS IT CONTROLLED? |  |  |
| HAVE YOU HAD ANY MAJOR OR MINOR SURGERY? IF YES, PLEASE STATE BELOW: |  |  |
| ARE YOU TAKING ANY MEDICATION, HERBAL OR NATURAL SUPPLEMENTS, TOPICAL LOTIONS OR CREAMS ON A DAILY BASIS? (FOR EXAMPLE- ANTIBIOTICS, HORMONES (HRT), RETIN-A, GLYCOLIC LACTIC ACID, CONTRACEPTION) IF YES, PLEASE STATE BELOW: |  |  |
| ARE YOU TAKING BLOOD THINNERS SUCH AS WARFARIN? |  |  |
| DO YOU HAVE OR SUFFER WITH COLD SORES? |  |  |
| DO YOU HAVE OR HAVE YOU BEEN EXPOSED TO HIV (AIDS)? |  |  |
| HAVE YOU HAD ANY SEMI-PERMANENT MAKEUP, IMPLANTS OR TATTOOS? |  |  |
| ARE YOU PREGNANT OR BREASTFEEDING? |  |  |
| DO YOU GET NERVOUS OR TWITCHY? |  |  |
| DO YOU SUFFER WITH CLAUSTROPHOBIA? |  |  |
| DO YOU SUFFER WITH ACTIVE ACNE? |  |  |
| DO YOU SUFFER ROSACEA? |  |  |
| HAVE YOU EVER TAKEN ROACCUTANE OR ACCUNTANE? IF YES, PLEASE STATE WHEN: |  |  |
| DO YOU HAVE ANY ACTIVE SKIN INFECTIONS SUCH AS IMPETIGO? |  |  |
|  | YES | NO |
| DO YOU HAVE ANY RAISED LESIONS OR SCARRING? IF YES, PLEASE STATE WHERE: |  |  |
| DO YOU BRUISE EASILY? |  |  |
| DO YOU BLEED EASILY? |  |  |
| DOES YOUR SKIN FEEL TIGHT, DRY OR EVEN FLAKE? |  |  |
| IS YOUR SKIN EVER SHINY AFTER CLEANSING? |  |  |
| DO YOU SUFFER WITH BLEMISHES OR BLACKHEADS? |  |  |
| HAVE YOU EVER EXPERIENCED PIGMENTATION DISORDERS SUCH AS MELASMA, CHLOASMA OR PORT WINE STAIN? |  |  |
| DO YOU HAVE ANY VASCULAR LESIONS SUCH AS VEINS OR BLOOD SPOTS? IF YES, PLEASE STATE WHERE: |  |  |
| DO YOU HAVE ANY BROKEN CAPILLARIES OR THREAD VEINS? IF YES, PLEASE STATE WHERE: |  |  |
| DO YOU BLUSH EASILY? |  |  |
| DO YOU SUFFER WITH HEAT RASH? |  |  |
| DO YOU SUFFER WITH ECZEMA OR DERMATITIS? IF YES, PLEASE STATE WHERE: |  |  |
| HAVE YOU HAD ANY SUN EXPOSURE IN THE LAST 4 WEEKS? IF YES, DID YOU BURN? |  |  |
| DO YOU CONSENT FOR THE THERAPIST TO USE BEFORE AND AFTER PHOTOS OF YOUR TREATMENT FOR ADVERTISING PURPOSES? INCLUDING SOCIAL MEDIA POSTS |  |  |
| DERMAPLANING TREATMENT ONLY | | |
| HAVE YOU HAD ANY RECENT CHEMICAL PEELS? IF YES, PLEASE STATE WHEN: |  |  |
| HAVE YOU HAD ANY WAXING 48 HOURS PRIOR TO YOUR DERMAPLANING TREATMENT? IF YES, PLEASE STATE WHERE: |  |  |
| DO YOU HAVE ANY TERMINAL HAIR (THICK/DARK HAIR) THAT YOU ARE NOT ACTIVELY REMOVING? |  |  |
| ARE YOU HAPPY FOR THE THERAPIST TO REMOVE THE TERMINAL HAIR DURING YOUR DERMAPLANING TREATMENT? |  |  |
| DO YOU HAVE ANY ALLERGIES TO MEDICATIONS, FOODS, LATEX, NICKEL OR OTHER SUBSTANCES? IF YES, PLEASE STATE BELOW: |  |  |

I …………………………………………………………………………………… CERTIFY THAT ALL OF THE INFORMATION I HAVE PROVIDED IS TRUE AND I HAVE ANSWERED ALL OF THE QUESTIONS ABOVE TO THE BEST OF MY KNOWLEDGE. I AM AWARE THAT IT IS SOLELY MY RESPONSIBILITY TO INFORM THE THERAPIST OF ANY CHANGES IN THE INFORMATION I HAVE GIVEN.

CLIENT NAME:

CLIENT SIGNATURE:

DATE:

THERAPIST NAME:

THERAPIST SIGNATURE:

DATE:

PATIENT ONGOING CONSENT FORM

|  |  |  |
| --- | --- | --- |
|  | YES | NO |
| Full name confirmed |  |  |
| D.O.B confirmed |  |  |
| Address confirmed |  |  |
| Any change in medical circumstances |  |  |
| Any new medication/supplements |  |  |
| Sun exposure in the last 4 weeks |  |  |
| Pregnancy |  |  |
| Have you even experienced and swelling, bruising, lumps or bumps from treatment |  |  |
| I consent to the treatment being carried out |  |  |
| Client sign date | | |
| Practitioner sign date | | |

|  |  |  |
| --- | --- | --- |
|  | YES | NO |
| Full name confirmed |  |  |
| D.O.B confirmed |  |  |
| Address confirmed |  |  |
| Any change in medical circumstances |  |  |
| Any new medication/supplements |  |  |
| Sun exposure in the last 4 weeks |  |  |
| Pregnancy |  |  |
| Have you even experienced and swelling, bruising, lumps or bumps from treatment |  |  |
| I consent to the treatment being carried out |  |  |
| Client sign date | | |
| Practitioner sign date | | |

|  |  |  |
| --- | --- | --- |
|  | YES | NO |
| Full name confirmed |  |  |
| D.O.B confirmed |  |  |
| Address confirmed |  |  |
| Any change in medical circumstances |  |  |
| Any new medication/supplements |  |  |
| Sun exposure in the last 4 weeks |  |  |
| Pregnancy |  |  |
| Have you even experienced and swelling, bruising, lumps or bumps from treatment |  |  |
| I consent to the treatment being carried out |  |  |
| Client sign date | | |
| Practitioner sign date | | |