Customer:

Email:

Phone:

Business Logo:

Completed: 2 Feb 2026 - 5:18 PM

Device Name: iPhone Mobile Website

IP Address: 81.97.204.145

Location: Leeds GB

Anti-Wrinkle Consultation & Consent Form

Anti-wrinkle injections use carefully measured doses of a prescription-only medication (Botulinum Toxin) to temporarily relax specific facial muscles responsible for expression lines. By reducing repetitive muscle movement, the appearance of wrinkles softens and the skin looks smoother and more refreshed. Results usually begin to appear within 3-7 days, reach their full effect at around 2 weeks, and typically last 4-6 months depending on the individual. Ongoing treatments are required to maintain results. A thorough consultation is required before any anti-wrinkle treatment to ensure medical safety, suitability, and the best possible results. Your medical history, previous treatments, muscle activity, and lifestyle factors help determine whether this prescription-only treatment is appropriate and which injection techniques should be used. Providing honest and accurate information is essential to avoid complications and to allow your practitioner to create a safe, effective, and personalised treatment plan.

1. Client Demographic Information

First Name: Camilla

Last Name: Patini

Address: 228 Rushmore Road, London, Greater London, E5 0HD

Email: camilla.camillapatini@gmail.com

Phone: 07721811253

Gender: Female

Birth Date: 6 Aug 1992

Referred by: N/A

Medical History & Skin Analysis

2. Are you currently under the care of a doctor or dermatologist?

No

3. If "Yes" please specify

Not Answered

4. Do you have any of the following conditions? Please answer truthfully, this ensures your treatment is safe and effective

None of the above

5. If "Yes" to any of these including current medication" or "Other Medical Condition", please specify

Not Answered

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6. Areas of concern (tick all that apply):

Bunny Lines

7. If "Other" please specify

Not Answered

8. When is the appointment scheduled?

3 Feb 2026

Cosmetic Treatment History

9. Please tick all that apply:

Anti-wrinkle injections in the past

10. If "Yes", please specify area and date

Not Answered

CONTRAINDICATION CHECK

Anti-wrinkle injections cannot be performed if any absolute contraindications apply, and may require postponement or additional precautions if relative contraindications are present.
It is essential to answer all questions honestly to ensure safe and appropriate treatment.

Absolute Contraindications:

11. Please tick any that apply:

Not Answered

Relative Contraindications:

12. Please tick any that apply:

Not Answered

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13. Are you currently on any of the following?

None of the above

Client's Consent (Mandatory)

Photographs are taken before and after treatment for medical documentation and client records.

14. Client Consent (Mandatory) Please confirm each statement:

I confirm that I have read, understood, and agree to follow the pre- and post-treatment information guide provided with this consultation and consent form., I confirm that the information I have provided is accurate, and I have disclosed all relevant medical history and allergies., I understand the general risks associated with aesthetic treatments, including bruising, swelling, asymmetry, infection, or temporary discomfort., I understand that results vary between individuals and that I may require further treatment for optimal or maintained results., I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction., I understand that all aesthetic treatments provide temporary results and will naturally wear off over time, I consent to photographs being taken for my medical record, with optional separate consent for marketing below., I consent to the processing of my personal data in accordance with the clinic’s privacy policy and understand I can withdraw consent at any time.

15. Photo & Marketing Consent.

I consent to my photos being used anonymously for training or educational purposes., I do not consent to any use of my photos beyond my medical record.

16. Please sign and date to confirm that you have read, understood, and agree to the statements above.

X Customer's Signature

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17. Client's Name

Camilla

X Employee's Signature

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19. Employee's Name

?

Practitioner Notes (For Internal Use Only)

20. For "Other", please specify area

Not Answered

Assessment:

Batch Number & Expiry Date:

Treatment Given / Units Used:

Post-Treatment Comments: