From: **Carrie Allcott** carrie.allcott@icloud.com
Subject: Fwd: Consultation Form .. Hi could I have one printed please.... :)
Date: 2 February 2018 at 11:02
To: TQ Print & Design adrian@tqprintanddesign.co.uk

CA

Consultation Form

If you are booking a treatment for the first time please fill out the Client Consultation form.

Personal Details

Name

Surname

Mobile

Address

Post Code

Email

Birthday

dd/mm/yyyy

Occupation

How did you hear about us

Medical History

Are you currently or within the last year under a physician's care?

☐ Yes ☐ No

If yes please state

Are you currently being seen by a physician for a medical condition that is not completely diagnosed?

☐ Yes ☐ No

If yes please state

Are You Currently Taking any Medication?

☐ Yes ☐ No

If yes please state

Do you have any of the following medical conditions? (Please check all that apply)

☐ Cancer ☐ Had Cancer in the last 5 years ☐ High Blood Pressure ☐ Low Blood Pressure ☐ Herpes ☐ Frequent Cold Sores ☐ HIV / AIDS ☐ Skin Disease ☐ Skin Lesions ☐ Seizure Disorder ☐ Any active infection ☐

Do you have any other health problems or medical conditions? (Please state)

Are you Pregnant or trying to become pregnant, if yes how many weeks are you?

Please list any topical medications or creams you are currently using.

Allergies

Have you ever had an allergic reaction to any of the following? Please check all that apply and describe the reaction you experienced

☐ Latex Cosmetics ☐ Massage Oils ☐ Cosmetics ☐ Aspirin ☐ Lashes ☐ Other

Please describe any reactions and list any other allergies that you have experienced

Skin Care History

Are you currently under the care of a dermatologist?

☐ Yes ☐ No

If yes, please state

Do you wear contact lenses?

☐ Yes ☐ No

Do you have any special skin problems pertaining to your face or body?

☐ Yes ☐ No

If yes, please specify

Do you have a tendency to redness?

☐ Yes ☐ No

A patch Test has been performed for:

Semi-permanent lashes ☐

Please agree to the terms and conditions below...

I certify that the preceding medical, personal and skin history statements are true and correct.I accept that any treatment I have is taken at my own risk. I certify that I have read and have completed the above to the best of my knowledge. I understand that failure to disclose information requested above may result in adverse side effects, unknown because of this to which I accept full liability/responsibility. I am aware that it is my responsibility to inform the Therapist of my current and ongoing medical or health conditions and it is essential for the caregiver to execute appropriate treatment procedures. I acknowledge the possible side effects of any beauty procedure.

I understand that Carrie reserves the right to charge for appointments cancelled or broken without 24 hours notice.

Accept

Client Print name

Date

dd/mm/yyyy

[redacted]