

CLIENT HISTORY FORM

NAME.....DATE.....

ADDRESS.....PHONE.....

Are you currently on any medication? If so some may affect your healing and colour outcome these medications include HRT and medication for Depression. Please tick any of the following that may apply to you.

- Diabetes
- Currently on Blood Thinners
- Taking Aspirin
- Any Blood Clotting Problems
- Heart Palpitations
- High Blood Pressure
- Hepatitis
- Facial Surgery Within the Last 3 Months
- Pregnancy
- Taking Fish Oil
- Glaucoma
- Dry Eyes
- Contact Lenses
- Eye Disorders
- Lash Enhancement serum
- Ever had Cold Sores
- Collagen Injections/Filler

Consent

I understand that this treatment is for cosmetic purposes only
 That no guarantees have been made to me regarding the results
 I am responsible for the "at home care" using only the aftercare product in my at home care advice if not I may have risk of infection or fading of pigments if not carried out fully
 I will not hold the Therapist/Trainer or student responsible in the event of any damage and shall not be entitled to take action against her at Law or in Equity for such treatment
 I consent to before and after photographs of this procedure which is at the Therapist's discretion
 I cannot donate blood for 6TH MONTHS from today
 I consent to the use of Topical Anaesthetics containing Lidocaine ,& Epinephrine.
 I am aware that I may require a follow up visit in 1-2 months time to achieve the final result or adjustment.
 I am aware that latex gloves may be used and consent to their use.
 I have been given an aftercare sheet.
 I am over 18 years of age

PROCEDURE.....COLOUR.....

NEEDLE SIZE.....

PROCEDURE.....COLOUR.....

THERAPIST.....

COST \$.....FOLLOW UP VISIT.....

I am satisfied with the results obtained from this procedure I have been informed that colour may vary as the skin heals I have been given aftercare instructions.

CLIENT SIGNATURE.....

(TO BE SIGNED AFTER TREATMENT).