|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name:** |  | | | **Date of Consultation:** | | |  | |
| **Address:** |  | | | | | | | |
| **Tel No:** |  | | | **Gender:** | | |  | |
| **Date of Birth:** |  | | | **Occupation:** | | |  | |
| **Email:** |  | | | | | | | |
| **Doctors Name & Address** |  | | | | | | | |
|  | | | | | | | | |
| **Do any of the following apply to you:** | | | | | | | | |
| Epileptic | |  | Pregnant/breastfeeding | |  | Arthritis | |  |
| Thyroid problems | |  | Lupus | |  | Anxiety | |  |
| Depression | |  | Diabetes | |  | Heart problems | |  |
| High/low blood pressure | |  | Acne | |  | Cancer | |  |
| Recent surgery (in last 6 months) inc cosmetic | |  | Bacterial/fungal infection | |  | Varicose veins/thrombosis | |  |
| Taking or recently taken Roaccutane (in last 12 months) | |  | Eczema/Psoriasis/ Dermatitis | |  | Auto-immune disorder | |  |
| **IF TICKED YES TO ANY OF THE ABOVE, WRITE IN FURTHER INFORMATION BELOW** | | | | | | | | |
| **Are you taking any of the following drugs: MAY CAUSE SENSITIVITY TO LED FACIAL TREATMENT** | | | | | | | | |
| Anti-anxiety drugs (benzodiazepines) | |  | Antibacterial drugs (e.g. chlorhexidine, hexachlorophene) | |  | Antibiotics (quinolones, sulphonamides, tetracyclines, trimethoprim) | |  |
| Antidepressants (tricyclics, SRRIs) | |  | Anti-fungals (e.g. griseofulvin, flucytosine) | |  | Antihistamines | |  |
| Anti-hyperglycaeamics (sulfonylureas) | |  | Anti-malarial (chloroquine, quinine) | |  | Anti-psychotics (phenothiazine, chlorpromazine) | |  |
| Calcium channel blockers (nifedipine, benoxaprofen) | |  | Cholesterol lowering agents (simvastatin, atorvastatin, lovastatin, pravastatin) | |  | Dermatology products (Psoralens, Retinoids) | |  |
| Diuretics (frusemide, thiazides, hydrochlorothiazide) | |  | Heart drugs (amiodarone, quinidine) | |  | Isotretinoin | |  |
| Lithium | |  | Melatonin | |  | Methotrexate | |  |
| Steroids/cortisone injections (celecoxib, ibuprofen, ketoprofen, naproxen, piroxicam) | |  | St John’s Wort | |  | **Other prescription medication** | |  |
| **Do you have any other relevant conditions not mentioned above?** | | | | | | | | |
| **Why have you come for your treatment?**  **AREAS OF CONCERN:** | | | | | | | | |

**General Data Protection Regulations: Client Consent & Declaration:**

**Why we need your personal data:** In order for **The Team** to provide safe and relevant treatments, it is necessary for us to collect only relevant personal information.

**How do we obtain your personal data:** We only hold information about you, which has been voluntarily provided to me by **you** (the client). We ask you to check the details are correct to the best of your knowledge and that you sign the bottom of the consultation form after checking to verify your knowledge and agreement to the data being held.

**Data retention:** In order to comply with insurance policies and legal procedures, **We are** required to hold your personal data for a period of 7 years.

**Storage and security of your personal data:** We will take all appropriate technical and organisational steps to protect the confidentiality, integrity, availability and authenticity of your data.

**Who can access your personal data:** Only relevant personnel within the company shall have access to your personal data. This is in the interest of conducting safe treatments on **you,** or in order that I may contact you in the case of last minute cancellations.

**Your rights:** You have the right to access, amend (if details are incorrect or out of date) or withdraw your personal data if you no longer wish to be a client, however, if you wish to withdraw your details, please make this known in writing. Please be aware that details of all treatments must be held (by law) for a period of 7 years.

I confirm that I have read the details above, and checked the contents of this consultation form, and believe to the best of my knowledge that the information I have given is correct and I am happy to proceed with treatments.

I am / not happy to subscribe to B’eautiful’s monthly newsletter to hear about events, courses and offers.

**Signed:** ………………………………………………………………………………. **Date:** ……………………………………………………..

**Therapist:** …………………………………………………………………………… **Date:** ……………………………………………………..

**CLIENT MEDICAL HISTORY CARD**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date** | **Any changes to medical records** | **If yes: note changes in box below** | **Client**  **Initials** | **Therapist initials** |
|  | Yes / No |  |  |  |
|  | Yes / No |  |  |  |
|  | Yes / No |  |  |  |
|  | Yes / No |  |  |  |
|  | Yes / No |  |  |  |
|  | Yes / No |  |  |  |
|  | Yes / No |  |  |  |
|  | Yes / No |  |  |  |
|  | Yes / No |  |  |  |