**[](https://www.google.com/url?sa=i&rct=j&q=&esrc=s&source=images&cd=&cad=rja&uact=8&ved=0ahUKEwjf54jihonUAhVJyGMKHThFBe4QjRwIBw&url=https://www.123rf.com/stock-photo/eyebrow.html&psig=AFQjCNGVD7D9gH_Kdi5_q55xJTSVcW3bkw&ust=1495733241579197)Everlasting Lashes Client Evaluation Form for Lash Extensions**

**CLIENT INFORMATION:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency Contact name and phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health History Please list any allergies you have (including cosmetics/ingredients):**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have any eye disease, condition or injury that has affected your hair/lash growth or loss? Yes/No**

**Please list all current medications you are taking (including over-the-counter herbs, vitamins and supplements)**:

**Is this the first time you have had lash extensions applied?** Yes / No

**Please indicate if you have worn within the last 60 days any of the following types of lashes:** \_\_\_ individual \_\_\_ strip \_\_\_flare

**Do you: \_\_\_\_ curl your lashes, \_\_\_\_perm your lashes, \_\_\_\_ tint your lashes, \_\_\_\_wear mascara**?

**Are you having lash extensions applied for**: \_\_\_\_a special occasion - or- \_\_\_\_ daily wear

**Do you wear contacts?** Yes / No

**Do you habitually rub, pull, or pick your lashes for any reason?**  Yes / No

**Do you have, or are you being treated for any eye illness or injury?** Yes / No

**Which side do you most often sleep on?** \_\_\_\_Right \_\_\_\_Left \_\_\_\_Stomach \_\_\_\_Back

**Are you able to lie on your back comfortably for 2-3 hours and keep your eyes closed?** Yes / No

**Desired length/style of lash extensions**: \_\_\_\_Natural \_\_\_\_Longer \_\_\_\_Dramatic

**Please check any of the following that might apply to you:**

Asthma or any respiratory (breathing) problems Yes No Currant Eye Irritation Yes No Light Sensitivity Yes No Extreme Stress Yes No

Allergic to adhesives, synthetics, latex or tape Yes No Thyroid Disease Yes No

Eating Disorder Yes No Alopecia Yes No

Recent Eye Surgery Yes No Temporary Hair Loss Yes No

Dry Eyes Yes No Sensitive Eyes Yes No

Glycerin Allergies Yes No Conjunctivitis Yes No

Perm. Eye Make Up Yes No Blepharoplasty (eye lift) Yes No

Migraines Yes No Iron Deficiency Yes No

Watery Eyes Yes No Diabetes Yes No

Any other health condition not listed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name (Printed)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name Signature) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lash extension specialist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_