## Ice Globe Facials

**Please take the time to read this form carefully and to understand any accompanying information if applicable.**

**Please answer all the questions below to the best of your knowledge.**

| | | |
|---|---|---|
| **Full name:** | | |
| **D.O.B** | | |
| **Address:** | | |
| **Mobile telephone number:** | | |
| **Home telephone number:** | | |
| **Email address:** | | |
| **Doctors name:** | | |
| **Doctors address:** | | |
| **Doctors telephone number:** | | |
| **Please tick the appropriate box** | **Yes** | **No** |
| **Do you have any current or chronic medical illnesses I should be aware of? If yes, please state below (for example- thyroid, heart conditions, cancer, cancer within your family, epilepsy, diabetes)** | | |
| **Do you suffer with diabetes? If yes, is it controlled?** | | |
| **Have you had any major or minor surgery? If yes, please state below:** | | |

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| **Are you taking any medication, prescribed, herbal or natural supplements, topical lotions, or creams daily? (For example- antibiotics, hormones (hrt), retin-a, glycolic lactic acid, contraception) if yes, please state below:** | | |
| **Are you taking blood thinners such as warfarin?** | | |
| **Do you have or suffer with cold sores?** | | |
| **Do you have HIV?** | | |
| **Have you had any semi-permanent makeup, implants, or tattoos?** | | |
| **Are you pregnant or breastfeeding?** | | |
| **Do you get nervous or twitchy?** | | |
| **Do you suffer with claustrophobia?** | | |
| **Do you suffer with active acne?** | | |
| **Do you suffer rosacea?** | | |
| **Have you ever taken Roaccutane or Accutane? If yes, please state when:** | | |
| **Do you have any active skin infections such as impetigo?** | | |
| | **Yes** | **No** |
| | | |
| **Do you have any areas of recent scar tissue? If yes, please state where?** | | |
| **Do you bruise easily? Any areas with sprains, swelling bruising?** | | |
| **Do you bleed easily? Are you high risk with blood clots?** | | |
| **Does your skin feel tight, dry, or even flake?** | | |
| **Do you have an active lymphatic infection?** | | |
| **Do you suffer from any Heart conditions? / Pacemaker? High blood pressure?** | | |
| **Do you suffer from Kidney disorders?** | | |
| **Do you have any vascular lesions such as veins or blood spots? If yes, please state where:** | | |
| **Do you have any broken capillaries or thread veins? If yes, please state where:** | | |
| **Do you blush easily?** | | |
| **Do you suffer with heat rash?** | | |
| **Do you suffer with eczema or dermatitis? If yes, please state where:** | | |
| **Have you had any sun exposure in the last 4 weeks? If yes, did you burn?** | | |

| | | |
|---|---|---|
| **Anything else I should Know? Please complete here:** | | |
| **Have you had any recent chemical peels? If yes, please state when:** | | |
| **Have you had any waxing 48 hours prior to your treatment? If yes, please state where:** | | |
| **Have you had laser hair removal?** | | |
| **Do you suffer with keloid scarring?** | | |
| **Emergency contact name & mobile number. ……**<br><br>**Please do not book or attend your appointment if you are unwell.**<br><br>**Please bring photo id and proof of address.**<br><br>**Please tick here if you would like to be signed up to our email and receive exclusive offers? Yes / no**<br><br>**I …… certify that all the information I have provided is true and I have answered all the questions above to the best of my knowledge. I am aware that it is solely my responsibility to inform the therapist of any changes in the information I have given.**<br><br>**Client name:**<br><br>**Client signature:**<br><br>**Date:**<br><br>**Skin Examination**<br><br>**Skin Tone: Pink Olive Mediterranean Asian Black**<br><br>**Type of skin: Fine Normal Thick Normal Secretions: Hypo Hyper Acne Wrinkles: _____ Deep Wrinkles: _____ Skin abnormalities: _____ Scars: _____ Date: _____ Size: _____ Colour: _____ Sensitivity: _____ Pigmentation spot: _____ Size: _____colour: _____ Professional Observation**<br><br>**Therapist name:**<br><br>**Therapist signature:**<br><br>**Date:** | | |

| | | |
|---|---|---|
| **Do you have any allergies to medications, foods, latex, nickel, or other substances? If yes, please state below:** | | |

| | Yes | No |
|---|---|---|
| **Full name confirmed** | | |
| **D.O.B confirmed** | | |
| **Address confirmed** | | |
| **Any change in medical circumstances** | | |
| **Any new medication/supplements** | | |
| **Sun exposure in the last 4 weeks** | | |
| **Pregnancy** | | |
| **Have you even experienced and swelling, bruising, lumps, or bumps from treatment** | | |
| **I consent to the treatment being carried out** | | |
| **Client signature:** | **date:** | |
| **Practitioner signature:** | **date:** | |

| | Yes | No |
|---|---|---|
| **Full name confirmed** | | |
| **D.O.B confirmed** | | |
| **Address confirmed** | | |
| **Any change in medical circumstances** | | |
| **Any new medication/supplements** | | |
| **Sun exposure in the last 4 weeks** | | |
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