NBF

Supporting the hair, beauty and barbering industries

Confidential

CLIENT HEALTHCARE QUESTIONNAIRE

(To be completed by the therapist and signed by the client)

Client reference number (ID) ……..……

Client's full name ……

Salon name ……..…..

To be completed by all new clients at least 48 hours in advance of a treatment. This allows enough time to arrange an allergy alert test or sensitivity test if required before the treatment takes place. The questionnaire will be reviewed with returning clients at each subsequent visit to identify any health changes.

As a professionally run salon, we put your safety first.

It is important we have an accurate record of your general health, including any allergies or any medications you are taking. This is because certain health conditions may indicate that a particular treatment or product is not suitable for you. If so, we will try to suggest alternatives wherever possible.

Certain treatments are age-restricted, as noted in this questionnaire. Your therapist will advise.

YOUR DETAILS

Full name.....

Address .....

.....

.....

..... **Postcode** .....

Email .....

Date of birth (if aged under 21) .....

Phone .....

GP's name and address .....

.....

.....

.....

Phone .....

KNOWN ALLERGIES

Some clients already know they are allergic to certain substances. Please provide full details in the section of the questionnaire about allergies.

For your peace of mind, we will ask you to check the ingredients list for the products we normally use when providing treatments. If a product includes a substance you are allergic to, we will try to find an alternative. If we have no suitable alternative, then we will put your safety first and we won't go ahead with the treatment.

ALLERGY ALERT TESTS

An allergy alert test is done to check whether you are or may be allergic to a particular product or substance. Allergy alert tests are vital for your protection.

You will need to have an allergy alert test at least 48 hours before your first treatment in this salon for hair colour, eyebrow and eyelash tinting, colouring facial or other body hair (aged 16 or over).

ALLERGY ALERT TEST QUESTIONS

If you have requested any of the above treatments, please answer the following questions:

Q1 Are you under 16? **Yes/No**

Q2 Have you ever had an allergic reaction to hair colour? **Yes/No**

Q3 Do you have sensitive, irritated or damaged skin in the area to be treated? **Yes/No**

Q4 Is this the first time you have had this treatment in this salon? **Yes/No**

Q5 Have you had any type of skin tattoo, including a temporary 'black henna' tattoo or permanent make-up, since your last colour treatment? **Yes/No**

Q6 Have you had an allergic reaction to any other products used in beauty treatments since your last visit? **Yes/No**

If yes, do you know which substance you are allergic to?

Substance name .....

.....

Allergy alert tests need to be repeated every 12 months or if the therapist is changing brand or product. Our team will make the arrangements for any allergy alert tests required.

MEDICAL HISTORY

Have you ever had (please tick all that apply):

Allergies to:

- Hair colour ☐
- Latex ☐
- Cosmetics or perfumes (which?) ..... ☐
- Massage oils (which?) ..... ☐
- Waxes ☐
- Medications (which?) ..... ☐
- Food (which?) ..... ☐
- Pollen (which, if known?)..... ☐
- Animals (which?) ..... ☐
- Other products (which?) ..... ☐

Do you have (tick all that apply):

- Arthritis ☐
- Asthma or other respiratory problems ☐
- Circulation problems ☐
- Claustrophobia ☐
- Diabetes ☐
- Epilepsy ☐
- Eczema ☐
- Facial surgery ☐
- Haemophilia ☐
- Migraines ☐
- Heart condition/pacemaker ☐
- Hepatitis B ☐
- HIV-Aids ☐
- Kidney or liver problems ☐
- Metal plates/pins/piercings ☐
- Moles or skin tags ☐
- Multiple sclerosis ☐

- Psoriasis ☐
- Stroke ☐
- Thrombosis/DVT ☐
- Varicose veins ☐
- Other conditions you think may be relevant (which?) ..... ☐

Do you currently have (tick all that apply):

- Acne ☐
- Back problems (eg pain, inability to lie flat for periods) ☐
- Bruising (where?) ..... ☐
- Cuts, abrasions, open wounds (where?) ..... ☐
- Eye infection ☐
- Fungal infection/athlete's foot ☐
- Herpes/cold sores ☐
- High or low blood pressure ☐
- Infectious skin disease ☐
- Loss of sensation (where?) ..... ☐
- Nail diseases/disorders ☐
- Sensitive skin (where?) ..... ☐
- Sinus problems ☐
- Sunburn ☐
- Swelling/oedema/undiagnosed lumps ☐
- Warts or veruccas ☐
- Any other condition you think may be relevant ..... ☐

Within the last six months have you had any of the following:

- Anti-wrinkle treatments eg Botox or dermal fillers in the treatment area? If so, when was your last treatment? ..... ☐
- Dermabrasion or a chemical peel ☐
- IPL laser or epilation ☐
- Tattoo ☐
- Operations in the last six months (what?) ..... ☐

Are you:

Pregnant (if so, how many weeks?) ☐

Breastfeeding ☐

Undergoing chemotherapy treatment for cancer ☐

(Please ask your oncologist or GP for a letter confirming you can have the treatment you have requested. Your therapist will ask for a copy of the letter.)

Taking any of the following:

Anti-coagulant medication ☐

Steroids ☐

Retinol (vitamin A1) ☐

Roaccutane/Accutane ☐

Hormones ☐

Oral antibiotics ☐

Other medication ☐

(if so, which and what are they for?) ……

……

……

(Your therapist will advise if you need a letter from your GP or other specialist confirming you can have the treatment requested.)

How would you describe your general physical condition?

Excellent ☐

Very good ☐

Good ☐

Not so good ☐

Poor ☐

Any further information you think may be relevant ……

……

……

Please detail any beauty treatments you have had in the past six months and where you had them:

……

……

……

……

……

Did you have any concerns or experience any reactions? If yes, what?

……

……

……

……

……

Which skincare products are you currently using?

……

……

……

……

……

Do you have any concerns or have you experienced any reactions? If yes, what?

……

……

……

……

……

DECLARATION

☐ I have read and understand the questions in this booklet, and to the best of my knowledge the answers are correct.

☐ I understand that I am responsible for informing the therapist of medical or health conditions and that I may not be able to have the treatment(s) I have requested in order to protect my wellbeing.

Name of client: .....

Client's signature .....

Date .....

For clients under the age of 16 or vulnerable adults

Please note that the range of treatments which can be provided for this age group or to vulnerable adults is restricted.

☐ On behalf of the client I confirm that I have read and understand the questions in this booklet, and to the best of my knowledge the answers are correct.

☐ I understand that I am responsible for informing the therapist of medical or health conditions on behalf of the client and that the therapist may advise the client not to have the treatment(s) they have requested in order to protect their wellbeing.

Name of client: .....

Name of client's parent/guardian/carer .....

Parent/guardian/carer's signature .....

Date .....

Therapist to sign once they have reviewed the healthcare questionnaire with the client (and/or client's parent/guardian where applicable).

Name of therapist .....

Therapist's signature .....

Date .....

DATA PROTECTION AND CLIENT RECORDS

We take your privacy seriously and the information we collect about you (which includes all of the personal information in this questionnaire, the client consultation form and the results of any allergy alert tests) will be held confidentially and in compliance with applicable data protection laws. Your personal information will be stored securely within our IT system or in a locked filing cabinet and can only be seen by members of the salon team.

Please tick the box below if you consent to us:

☐ Keeping a record of your personal information while you are a client of the salon.

☐ Holding records of your personal information for four years after your last visit, after which your records will be deleted (unless we are required by law to keep your personal information for any longer period).

Data protection and under-16s

We take privacy seriously, especially when it concerns children under the age of 16.

We require the consent of a parent, carer or guardian for us to collect personal information relating to a child under the age of 16 which will be held for a minimum of four years. Information we collect will be held securely within our IT system or in a locked filing cabinet and can only be seen by members of the salon team.

If you consent please sign below:

I ..... (**name of parent, carer or guardian**) give permission for the salon/barbershop to collect and hold personal data about:

..... (**name of the child under 16**) for four years, after which the data will be deleted (unless we are required by law to keep your personal information for any longer period).

Signature of parent/carer/guardian .....

YOUR CONSENT TO STAY IN TOUCH

As a valued client we'd like to stay in touch with you. We will only use your personal information to manage appointments for the services or treatments we provide to you.

We would also like to contact you about special offers, birthday treats, new products or loyalty scheme rewards. If you consent to us contacting you for these purposes, please tick to say how you would like to hear from us:

☐ Post

☐ Email

☐ Phone

☐ Text message

You can opt out of marketing messages from us at any time. Contact the salon manager to opt out or to see a copy of our privacy notice.

Name of client: .....

Client's signature .....

Date .....

ADDITIONAL NOTES

Supporting the hair, beauty
and barbering industries

National Hairdressers Federation

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www.nhf.info