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**CONSULTATION AND CONSENT FORM**

**CLIENT PERSONAL INFORMATION**

|  |  |
| --- | --- |
| Client First Name  |  |
| Last Name  |  |
| Title  | Date of Birth  |
| Address  |  |
| Post Code:  |  |
| Home Tel No  | Mobile No  |
| Email Address  |  |
| Emergency Contact Name and Mobile No  |  |
| Doctor's Name  |  |
| Doctor's Address  |  |
| Post Code  |  |
| Doctor's Tel No  |  |
| What is your ethnic group?  |  |
| Do you wear contact lenses?  |  |

**CLIENT LIFESTYLE**

|  |  |  |  |
| --- | --- | --- | --- |
| What is your occupation?  |  |  |  |
| Do you work in a centrally heated or air-conditioned environment?  |
| Are you city based?  |  |  |  |
| Do you work mainly outdoors?  |  |  |  |
| Do you have children and if so, how old are they?  |  |
| Do you smoke cigarettes?  |  | If so, how many per day?  |
| What is your suntanning history?  |  |  |  |
| When you go in the sun without sunscreen do you? …  |
|   | * Burn easily and never tan?
 |  |  | * Burn easily and then tan?
 |
|   | * Tan and rarely burn?
 |  |  | * Never burn in the sun
 |
| Do you use sun beds?  |  | How often?  |
| Do you wear sunscreen daily?  |  | If so, what SPF Factor do you use?  |
| Does your sunscreen a broad spectrum (UVA/UVB)?  | Do you use a topical antioxidant? Ie: Vitamin C. |
| When was your last exposure to intense  | Are you planning an overseas holiday in the  |
| sunlight?  |  | next 4 -6 weeks?  |
| Have you ever had skin cancer?  |  | Do you have any marks or blemishes on your  |
|  |  |  | skin that has changed or seem not to be  |
|  |  |  | able to heal?  |

Additional Information:

* Do you suffer from any digestive problems such as IBS or constipation?
* Do you have any dietary intolerances or allergies?
* How many times do you exercise each week?
* What type of exercise do you do?
* How much fresh air do you get each day?

Please list ALL medication that you are currently on below, and for what medical condition:

**CLIENT MEDICAL HISTORY FORM**

|  |
| --- |
| Answer the following questions with a **‘TICK’ for YES or a ‘X’ for NO** and give further details  |
| where required.  |  |
| Are you, or might you, be pregnant?  | Are you trying to become pregnant?  |
| Are you breast feeding?  | When is your next menstrual period due?  |
| Are you currently feeling well?  |  |
| Have you had any issues of ill health, even the most minor, in the last 4 weeks?  |
| Give details  |  |
| **Are you suffering from, or have you ever been diagnosed with any of the following**  |
| **Conditions….**  |  |
| Diabetes?  | High / low blood pressure?  |
| Epilepsy?  | Heart disease/ heart condition?  |
| Anaphylaxis?  | Hay fever?  |
| Hepatitis / HIV?  | Rheumatoid Arthritis?  |
| Lupus?  | Haemophilia?  |
| Psoriasis?  | Eczema?  |
| Anaemia?  | Alopecia?  |
| Cancer?  | What type and how long ago?  |
| Polycystic ovarian Syndrome?  | Keloid or hypertrophic scarring?  |
| Anxiety or Depression?  | Mental health issues?  |
| Thyroid problems?  | Asthma / lung disease?  |
| Fainting / dizziness/ vertigo?  | Kidney/ liver problems?  |

**CLIENT SELF ASSESSMENT**

**Which of the following do you feel best describes your skin type?** ‘Tick‘ your answer…

* Very oily skin, large pores
* Oily skin
* Combination skin, oily T-Zone, dry to normal cheeks
* Normal well-balanced skin
* Dry Skin
* Sensitive Skin
* Blemish prone skin
* Acne Skin
* Easily bruised skin

What are your main skin concerns?

What results would you like to achieve from a course of treatment for any of your skin
concerns?

Have you received any of the following treatments within the last 3 months? State how long ago.

|  |
| --- |
| Waxing in the area to be treated |
| Electrolysis ( hair removal) |
| A chemical peel |
| Laser / IPL hair removal |
| Laser/ IPL skin regeneration or another laser treatment? |
| Permanent makeup / Tattooing |
| Dermal Roller |
| Microdermabrasion |
| Botulinum Toxin Injections |
| Dermal Filler Injections |
| Hair colouring |
| Other - Please state |

**INFORMED CONSENT TO TREATMENT – client to sign before treatment to commence.**

 Client Name:

 Client Address:

 Date of Birth: Treatment to be received:

**CONSENT FORM**

**Client Statement –** (please read and sign below)

* *The information I have given within this document is, to the best of my knowledge correct. I
have not withheld any known medical history or condition.*
* *I have read and I understand the Consultation form and that I am over 18 years of
age (or my parent or legal guardian is giving consent on my behalf) that:*
* I understand that the conditions listed in the consultation form and consent form
can make unsuitable for the required treatment. It is my responsibility to inform
my practicioner if my circumstances change, on each and
every visit for treatment.
* I have been informed that the person providing my treatment is a fully qualified
injector or medical aesthetic practitioner and is suitably qualified to
perform this procedure.
* I have been fully informed about the procedure I am to receive including the
possible side effects and the aftercare procedures I must follow
* I freely assume responsibility for any risks of complications or injury from known or
unknown causes associated with, relating to, or otherwise arising out of this
procedure.

**GP Disclaimer:**

* I understand that the General Medical Council advise that General Practitioners are kept
fully informed about all treatments undertaken by their patients. Either I have informed my
General Practitioner, or in signing this form I am exercising my right not to inform my
General Practitioner about the treatment I am about to undertake.
* I have read and understood this consent form, all the above matters have been explained to
me and my questions have been addressed and answered to my satisfaction.

**Client Signature:** Date:

Print name:

**Practitioner Signature:**  Date:

Print Name: