CONSULTATION FORM

Please note this form must be kept for a minimum of 7 years for insurance purposes (all sections with a * need to be completed)

*Client name _____ *Date of birth _____/_____/_____

Address _____

_____

_____

Postcode _____

*Contact number _____

Mobile _____

Email address _____

What communications would you like to receive from us?

Appointment Reminders ☐

Promotions and Offers ☐

Newsletters ☐

Other_____ ☐

How would you like to receive them?

Phone ☐

Mobile SMS ☐

Email ☐

Post ☐

Other_____ ☐

***Doctor's name and address**

_____
_____
_____

*** Previous treatments and reason for treatment**

_____
_____
_____
_____
_____
_____

***MEDICAL HISTORY**

If any are marked yes, please go into more detail in the space under the condition.

Heart conditions/pacemaker yes /no

Severe circulatory disorders/DVT yes /no

Diabetes yes/no

Skin disorders yes/no

Kidney problems yes/no

Swelling/oedema yes/no

Haemophilia yes/no

Cancer yes/no

Limitation of body movement/arthritis yes/no

Are you pregnant yes/no

Epilepsy yes/no

Prone to keloid scarring yes/no

Hormone imbalance yes/no

Stroke yes/no

Claustrophobia yes/no

Hepatitis yes/no

Metal plates/pins/piercings yes/no

Recent scar tissue/surgery yes/no

Respiratory problems yes/no

Allergies yes/no

High/low blood pressure yes/no

Operations within 6 months yes/no

***Any other medical conditions/ailments yes/no**

Please specify _____

***Medication/treatments / additional information**

Steroids yes/no

Other medication yes/no

Ultra violet exposure yes/no

Any other medications yes/no
*Please specify

Retinol or Roaccutane yes/no

Products containing fruit acids yes/no

Microdermabrasion yes/no

Laser/IPL yes/no

_____
_____

*****Declaration I declare that the above information I have given concerning my health is correct

Signature_____ Date_____/_____/_____

*Updates/Changes

Please advise us of any personal or medical changes applicable to this consultation form since your last treatment with us? If none, state NONE with your signature and date.

Date	Amendment of details	Signature

Please NOTE remember to attach all relevant patch test forms and parental consent forms where applicable

Declaration Form in response to Covid-19/Coronavirus - PLEASE COMPLETE FULLY

- **Have you tested positive or had treatment for COVID-19?**

- **Have you, or has anyone you are in close contact with, had any of the following signs or symptoms associated with coronavirus [list latest signs and symptoms]**

- **Have you been strictly following the social distancing measures outlined by the government during COVID-19?**

- **Did you check your temperature this morning and was it normal?**

- **Are you happy to follow our guidelines as per our separate sheet 'Our Response to Covid-19'?**

- **Do you declare that you will contact us if you are diagnosed with Covid-19 that you will make us aware as soon as possible?**

Please acknowledge that by signing this declaration that you are entering the salon and having treatments done at your own risk, we have all the correct safety measures in place, however we cannot guarantee that you will not be exposed to the virus:-

Signed: _____ **Print:**_____

Date:_____

Please read our separate information leaflet thoroughly as we reserve the right to refuse treatment at any point.