Eyelash Lift Consultation Form

Name:

Address:

Contact number:

Email:

D.O.B:

Do you have or ever had any of the following: (circle please)

Epilepsy	**Depression/Anxiety**
Diabetes	**Respiratory Condition**
Heart Condition	**IBS/Chrones Disease**
High/Low Blood Pressure	**Arthritis/Rheumatism**
Thrombosis	**Bruising/Swelling**
Chemotherapy/Radiotherapy	**Cuts/Abrasions**
Varicose Veins	**Recent Fractures**
Circulatory Disorders	**Recent Scars**
Pregnancy	**Currently taking medication**
Skin Conditions	**Wear contact lenses**
Trichotillomania (hair pulling)	**Eye Infections**
Recent eye operation	**Watery eyes**
Styes	**Severe Eczema**
Dry eye syndrome	**Glaucoma**

<u>Please complete and sign</u>

Have you received a patch test?

Date of Patch Test:

Was your patch test positive or negative?

Would you like a Gentle or Full lift?

Have you had a lash lift before, if so when?

Has your therapist explained the treatment procedure?

Are you age 16 and over?

Are you aware of all the aftercare information?

Are you aware that the treatment might not be successful?

Incase of any irritation or questions please contact Therabeautic within 24 hours of procedure.

Please sign and Date

Client Signature:

Date:

Client Treatment Plan:

Comments: