BOXMOOR BEAUTY ROOM

SURNAME……………………………………………………………………………….FIRST NAME……………………………………MR/MRS/MISS/MS/…..

ADDRESS………POST CODE………………………..

EMAIL ADDRESS………DOB………………………….

CONTACT NUMBER…………………………………………………………………………….OCCUPATION……………………………………………………….

GP……………………………………….SURGERY…………………………………………………………PHONE…………………………………………………….

MEDICAL HISTORY………………………………………………………………MEDICATION…………………………………………………………………….

OPERATIONS/SCAR TISSUSES WITHIN 6 MONTHS…………………………………………………………………………………………………….

ALLERGIES/ALLERGIC REACTION TO PREVIOUS TREATMENTS………………………………………………………………………………….

BODY/INTIMATE WAX? **Y/N** GELS/DIPNAILS/MANICURE/PEDICURE? **Y/N** LASHLIFT/TINTING/BROW SHAPE/SPRAY TAN? **Y/N**

CLAUSTROPHOBIA? **Y/N** BACK/HIP/KNEE PROBLEMS? **Y/N** HIGH/LOW BP? **Y/N** EPILEPSY? **Y/N** CANCER? **Y/N** ARTHRITIS? **Y/N**
MENOPAUSAL? **Y/N** DIABETES/ASTHMA? **Y/N** PREGNANT? **Y/N** PSORIASIS/ECZEMA? **Y/N** MOLES/TB/VARICOSE VEINS? **Y/N**
CONJUNCTIVITIS/STYE? **Y/N** WARTS/ATHLETE'S FOOT/VERRUCAS? **Y/N** CONTACT LENSES? **Y/N** OTHER?.................................

HOW DID YOU FIND OUT ABOUT US? GOOGLE/FACEBOOK/INSTAGRAM/RECOMMENDATION/OTHER?…………………………………

I agree that the information I have given is correct. I understand that I am responsible for notifying my therapist if my medical or contact details should change before my treatments.

CLIENTS SIGNATURE……DATE………………………………..

THERAPIST SIGNATURE……………………………………………………………………………………………………DATE…………………………………

PATCH TEST? PERM (**RE/LE**) TINT (**RE/LE**) HENNA (**RE/LE**) MYSCARA (**RE/LE**) LASH GLUE (**RE/LE**) DATE/TIME………………………….