Consultation Form

Name

Date of Birth	Date

Address

Email (do I have permission to contact you with offers and information on treatments/products? YES/NO)

Phone No	Work No

Doctor

Do I have permission to contact you by phone or leave a message? YES/NO

Do I have permission to show non identifying photos for education purposes? YES/NO

CONCERNS (please circle)

ACNE LARGE PORES ACNE SCARRING DEHYDRATED SKIN

CYSTS/NODULES AGE SPOTS OILY SKIN MELASMA REDNESS

DULL COMPLEXION BLACKHEADS EXCESSIVE FACIAL HAIR ROSACEA

BODY ACNE ROUGH/UNEVEN SKIN TEXTURE MILIA SUN DAMAGE

FREQUENT BREAKOUTS OTHER_____

How would you describe your skin? (please circle)

OILY DRY COMBINATION SENSITIVE

How would you describe your stress levels? (please circle)

LITTLE MODERATE HIGH SEVERE

Are you currently under the care of a GP? YES/NO

Details

Are you currently under any medications, either topical or oral? YES/NO

Details

Ethnic Background (Parents, Grandparents, Great Grandparents)

Details

Do you have any allergies to food/medication? YES/NO

Details

Do you smoke? YES/NO

Are you prone to cold sores? YES/NO

Do you have an allergy to latex? YES/NO

Do you tan regularly? (In the sun or on tanning beds?) YES/NO

Are you claustraphobic? YES/NO

Are you epileptic? YES/NO

Have you ever taken a reaction to a facial or body treatment/product before? YES/NO

Have you received a face peel in the last 14 days YES/NO

Have you received any laser treatments in the last 4 weeks YES/NO

Details

Please circle what skin care products you are currently using

CLEANSER TONER MOISTURISER FACIAL OIL SERUM SPF

EYECREAM EXFOLIATING SCRUB SELF TANNER ENZYMES MAKEUP

OTHER_____

I _____ give my consent for the following treatment, Dermaplaning, to be performed by …….. I understand the treatment procedure and the benefits of it, and there are reasons I cannot have this treatment performed on me, including but not limited to Diabetes, Cancer, Active Acne, A history of Bleeding Disorders and the inability for blood to coagulate following an injury and sunburnt/windburnt skin, therefore I have disclosed everything in this form. Certain

medications including blood thinners, higher dosages of Aspirin and Accutane are contraindicated for this treatment due to the possibility of nicks or cuts.

I certify that I am not taking any of the above medications or experiencing any of the above conditions.

I understand this treatment involves the use of a sterile, surgical blade to remove dead skin cells and vellus hair. As with the use of any sharp instrument there is a possibility of nicks or cuts. While every precaution is taken I understand the risks

Client Signature Date

Practitioner Signature Date

Treatment Dates	Notes/Products used & Recommended