**Private & Confidential Client Consultation Form**

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| **Client Details**  |
| Client Ref:  | Telephone Number:  |
| Address:  | Mobile Number:  |
|  | Occupation:  |
| Postcode:  | Date of Birth:  |
| Email:  | Gender:  |

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| **Medical History**  |
| **Do you or have you ever suffered from:** Eye infections **□** Undiagnosed lumps **□** Skin disorders **□** Cuts, abrasions, swellings etc **□** Extreme sensitive, fluttery eyes **□** History of allergies, severe sensitivity to cosmetics etc **□**  |
| Allergies:  |
| page26image50721152Phobias:  |
| Do you wear contact lenses?  | page26image50703232page26image50694784*Yes/No* page26image50703424page26image50702080 | Are you claustrophobic?  | page26image50724224page26image50695744*Yes/No* page26image50686080page26image50678976 |
| Have you ever had eye treatments before?  | *Yes/No*  |
| If *YES*, did you experience any problems?  |
| Additional Comments:  |

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| page26image49089712**Patch Test Information**  |
| Date:  |  |  | page26image50423168page26image50416640 | page26image50417984page26image50418752 |
| Date:  | page26image50426624 | Reaction:  | *Positive/Negative*  |

**CLIENT STATEMENT & AGREEMENT**

I acknowledge that all the information on this consultation sheet above my signature is accurate and correct to the best of my knowledge. I accept full and complete responsibility for my own emotional and/or physical well-being both during and after this therapy and/or training session. I agree to inform the therapist of any changes to my circumstances during any subsequent treatments. I realise that any advice given to me to carry out between sessions is important and I agree to make every effort to carry this out. I understand that no claim to cure has been made and realise that treatments should not replace conventional treatments.

**Signed: (Client) Date:**