**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: |  |  | page26image50423168  page26image50416640 | page26image50417984  page26image50418752 | |
| 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:**