## Private & Confidential Client Consultation Form

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

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

| **Patch Test Information** | | | |
|---|---|---|---|
| Date: | | | |
| Date: | 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:**