THE HAYNES ST ESTHETIC CLINIC

Henna Brows Clients

The Clinic is required to collect from clients the information in this form.
Thank you for your understanding. Contents are kept confidentially.
PLEASE USE BLOCK LETTERS IN ALL FORM FIELDS

Client Name	**Date of birth: DD/MM/YYYY**

Client Address

Client Phone Number

Client Email Address

Emergency Contact Name and Number

Do you presently have - or previously had - any of the following? (please circle YES or NO)

History of MRSA (staph)	YES / NO	Have you had a henna treatment before?	YES / NO
Diabetes	YES / NO	Have you had your brows/lashes tinted before?	YES / NO
Hepatitis (A, B or C)	YES / NO	• If so, did you have a reaction?	YES / NO
Easy bleeding/bruising	YES / NO	Have you had any reactions to hair dye?	YES / NO
Pregnant or breast feeding	YES / NO	Reactions to any beauty services in the past?	YES / NO
Autoimmune disorder	YES / NO	Are you receiving IPL or laser treatments?	YES / NO
Cancer? (When)	YES / NO	Contact lenses wearer?	YES / NO
Chemotherapy/radiation	YES / NO	Dry skin	YES / NO
Botox or cosmetic fillers	YES / NO	Oily skin	YES / NO
Recent surgery	YES / NO	Do you get spray tans?	YES / NO
Roaccutane (for acne)	YES / NO	Chemical peels? (When:)	YES / NO
Eczema, dermatitis or psoriasis	YES / NO	Do you use any products containing Retin-A, AHA/BHA?	YES / NO
Allergic reaction to any medications or ingredients?	YES / NO (please list):		
Any medications/vitamins:	YES / NO		
Any diseases or disorders not already covered?			

I agree that all of the above information is true and accurate to the best of my knowledge.

Signed: _____ Date: _____ / _____ / _____.