THE HAYNES ST ESTHETIC CLINIC

Waxing, Tinting, Spray Tans, Microdermabrasion, LED Light Therapy & Dermaplaning Client Form

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**	**Male / Female**

Client Address

Client Phone Number

Client Email Address

How did you hear about us?

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

Are you pregnant?	YES / NO	Do you suffer from any allergies?	YES / NO
Are you on any medication?	YES / NO	Do you have any injuries?	YES / NO
Have you had surgery in the last 6 months?	YES / NO	Do you have any cuts or abrasions?	YES / NO
Do you have any bruises?	YES / NO	Do you suffer from claustrophobia?	YES / NO
Are you on any weight loss program?	YES / NO	Do you drink 1-2 standard units of alcohol per day	YES / NO
Do you consume 8 glasses of water per day?	YES / NO	Do you suffer from any skin conditions?	YES / NO
Do you have any form of cancer?	YES / NO	Do you suffer from thrombosis?	YES / NO
Do you suffer from epilepsy?	YES / NO	Do you suffer from high or low blood pressure?	YES / NO
Do you suffer from heart conditions?	YES / NO	Do you suffer from diabetes?	YES / NO
Are you using any Retin A or Vitamin A	YES / NO	Are you or have you used Roaccutane, Accutane or any other acne medication?	YES / NO
Are you using blood thinning medication or cortisone?	YES / NO	Are you using or have you used IPL, SPL or laser treatments?	YES / NO
Do you suffer from cold sores?	YES / NO	Do you have conjunctivitis?	YES / NO
If you are having a facial treatment, please list facial products that you are currently using:			

If you answered YES to any of the above, please give details here:

Please circle YES or NO below:

YES / NO	These photographs may be used for website, Facebook, Instagram and other publicity purposes so long as my identity cannot be seen in them.

YES / NO	I consent to photographs for the purpose of monitoring response to therapy.

SIGNATURES

CLIENT SIGNATURE: **……. ……. …….** **DATE: ……. ……. …….**

THERAPIST SIGNATURE: **……. ……. …….** **DATE: ……. ……. …….**

*** END OF FORM ***