Advanced Treatment Consultation Form

Name: _____ Surname: _____

Date of Consultation: _____ dd / mm / yyyy Street Address: _____

City: _____ Postcode: _____

Tel No: _____ Mobile: _____

Date of Birth: _____ dd / mm / yyyy Occupation: _____

Email: _____ Doctor Name: _____

Doctor Address: _____

DO YOU SUFFER FROM ANY OF THE FOLLOWING:

Do you suffer from any of the following:

- [ ] Epileptic
- [ ] Cancer
- [ ] Lupus
- [ ] Depression
- [ ] Heart Conditions
- [ ] Acne
- [ ] Auto-immune Disease
- [ ] Convulsion
- [ ] Glaucoma/Cataract
- [ ] Venereal Disease
- [ ] Phlebitis
- [ ] Epilepsy
- [ ] Recent Facial Surgery-6months
- [ ] Fungal infection
- [ ] Allergies/hay fever/food
- [ ] Rosacea
- [ ] Poor healing or not clotting
- [ ] Bronchitis
- [ ] Herpes simplex
- [ ] Scleroderma, collagen vascular diseases
- [ ] Asthma
- [ ] Keloid scarring
- [ ] Other
- [ ] Pregnant
- [ ] Thyroid Problems
- [ ] Anxiety
- [ ] Diabetes
- [ ] High/low blood pressure
- [ ] Cancer
- [ ] Arthritis
- [ ] HIV/Hepatitis
- [ ] Stomach Ulcers
- [ ] Bells/Facial Palsy
- [ ] Hypoglycemia
- [ ] Heart Disease/Angina
- [ ] Bacterial infection
- [ ] Taking or recently taken Roaccutane in last 12 months
- [ ] Sensitive/Dry Skin
- [ ] An anaphylactic reaction
- [ ] Eczema/Psoriasis/Dermatitis
- [ ] Dandruff
- [ ] Prone to fainting
- [ ] Use of isotretinoin eg. Accutane in the last 6 months
- [ ] Kidney conditions
- [ ] Bleed or bruise easily

TICKED YES TO ANY OF THE ABOVE , WRITE IN FURTHER INFORMATION BELOW:

ARE YOU TAKING ANY OF THE FOLLOWING DRUGS:

Are you taking any of the following drugs:

- [ ] Anti-anxiety drugs (e.g. alprazolam chlordiazepoxide)
- [ ] Anti-malarial (e.g. chloroquine, quinine)
- [ ] Melatonin
- [ ] Retinol
- [ ] Antibacterial drugs (e.g. chlorhexidine, hexachlorophene)
- [ ] Anti-psychotics (e.g. phenothiazines)
- [ ] Methotrexate
- [ ] Anticoagulant
- [ ] Antibiotics (quinolones, sulphonamides, tetracyclines, trimethoprim)
- [ ] Diuretics (e.g. frusemide, thiazides)
- [ ] Aspirin
- [ ] Antidepressants (e.g. tricyclic)
- [ ] Heart drugs(e.g. amiodarone, quinidine)
- [ ] Vitamin C
- [ ] Other medication or supplements
- [ ] Anti-fungal (e.g. griseofulvin)
- [ ] Acne drugs (Isotretinoin/roaccutan)
- [ ] Vitamin A
- [ ] Melanin Suppressors
- [ ] Anti-hyperglycaemic drugs (sulfonylureas
- [ ] Steroids/cortisone
- [ ] Phenothiazine

What other prescription medication are you taking (recreational or over the counter in the last 3 months)?

Are you currently seeing a doctor or clinic?

Are you receiving treatment for any medical condition?

Have you recently had any surgery (in the last 12 months)?

Are you undergoing any medical procedures?

Do you have any other relevant conditions not mentioned above?

Have you undergone any chemical, mechanical, laser resurfacing treatment in the last 6 weeks?

have you ever had any facial cosmetics injections (when and what area of the face)?

Last/next planned holiday or being in the sun?

Do you smoke?

Units of alcohol per week?

Have you had a tetanus or any other vaccination in the last 6 weeks?

Are you pregnant or currently breastfeeding?

Skin type and conditions

With 1 being fair and 6 being dark, how would you describe your skin? Please select.

- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5
- ◯ 6

Clients usual skincare routine-

Previous treatment history?

My practitioner has explained the treatment throughly. I have been informed about the expected results and side effects, if any, of the treatment. I understand that results vary from patient to patient and all results are not guaranteed.

Some procedures may involve anaesthetic. I fully understand the complications and risk of this.

I agree to follow all aftercare advice provided to me by my therapist.

I can confirm I have been given the opportunity to raise any questions or concerns I may have regarding the procedure I intend to undergo.

Note: we offer discounted model prices for advanced treatments under a no refund policy. By signing the below, you acknowledge these terms and conditions.

Client Signature: *

Date: *: _____ dd / mm / yyyy

Therapist Signature:

Date: _____ dd / mm / yyyy