

CLIENT CONSENT FORM

TREATMENT TYPE *: _____ Name *: _____

Gender: *

☐ Male ☐ Female

Date of Birth *: _____ dd / mm / yyyy Tel No (Daytime) *: _____

Mobile Tel No *: _____ Address *: _____

Postcode *: _____ Email Address *: _____

Drs Name *: _____ Tel No *: _____

Address *: _____

MEDICAL HISTORY

Medical History

- | | |
|---|--|
| ☐ Aesthetic Treatments | ☐ Anti-depressants |
| ☐ Asthma/Breathing Difficulties* | ☐ Botox |
| ☐ Cancer (Any form) | ☐ Collagen/Fillers |
| ☐ Diabetes | ☐ Epilepsy |
| ☐ Headaches / Migraine | ☐ Heart Condition |
| ☐ High / Low Blood Pressure | ☐ Highly Sensitive/Delicate Skin* |
| ☐ Hormone Irregularities | ☐ HRT |
| ☐ IBS or other Bowel Conditions | ☐ Inflammation / Infection |
| ☐ Kidney Related Problems | ☐ Major Operations |
| ☐ Metal Implant (incl. IUD) | ☐ Multiple Sclerosis |
| ☐ Moles | ☐ Over/Under-Active Thyroid |
| ☐ Pacemaker | ☐ Pregnancy / Breast-feeding |
| ☐ Prosthesis / Silicone Implant | ☐ Recent Operations |
| ☐ Retin A / Roaccutane | ☐ Semi-Permanent Make-Up* |
| ☐ Severe / Active Acne* | ☐ Severe Muscle Conditions |
| ☐ Skin Disorders | ☐ Skin Lesions Cuts / Burns |
| ☐ Thrombosis / Phlebitis | ☐ Tumours |
| ☐ Varicose Veins | |

*CONTRA-INDICATIONS (specific to microdermabrasion procedures)

General Notes

Allergies

Currently Under Medical Supervision For:

Medical History Operations:

☐ Smoke ☐ Drink

SKIN ASSESSMENT

Skin Assessment

- ☐ Acne
- ☐ Dehydrated
- ☐ Dry
- ☐ Milia
- ☐ Oily
- ☐ Photosensitivity
- ☐ Seborrhea
- ☐ Skin Tags
- ☐ Block Pores
- ☐ Dilated Capillaries
- ☐ Mature
- ☐ Moles
- ☐ Open Pores
- ☐ Scar Tissue
- ☐ Sensitive
- ☐ Sun Exposure

Regular Skincare Routine:

Any Other Medical Conditions:

TARGET AREAS OF CONCERN

TARGET AREAS OF CONCERN

TREATMENT EXPECTATIONS

TREATMENT EXPECTATIONS

BEFORE IMAGE TAKEN c AFTER IMAGE TAKEN

☐ BEFORE IMAGE TAKEN ☐ AFTER IMAGE TAKEN

The information I have given is to the best of my knowledge correct. I have not withheld any known medical history or condition.

I understand that to achieve optimal results, I will need multiple treatments. I understand that results may vary in different treatment areas and that results are not guaranteed.

I understand that with abrasion, ultrasonic and heat based treatments that there may be some short term effects, such as reddening and mild discomfort. I have read and understand the consent form, the treatment has been explained to me and my questions have been addressed and answered to my satisfaction.

☐ I consent to the treatment being undertaken.

☐ I consent for my data to be collected and stored.

Client Name in Full *: _____

Client Signature *

Date *: _____ dd / mm / yyyy

Name of Therapist *: _____

Date *: _____ dd / mm / yyyy

TREATMENT RECORD CARD

Date: _____ dd / mm / yyyy

Treatment: _____

Machine Settings: _____

Product Used/Recommended: _____

Measurement

Before: _____

After: _____

Photo: _____

Therapist Name *: _____

Customer Signature *