Consultation Form

Client name: _____

Home Telephone: _____ Mobile: _____

Email to subscribe to our mailing list and receive confirmation of appointments:_____
_____

Date of birth: _____

Medical History			**Additional Information**
Heart conditions/pacemaker	Yes	No	
Severe circulatory disorders/DVT	Yes	No	
Diabetes	Yes	No	
Skin disorders	Yes	No	
Kidney problems	Yes	No	
Swelling/oedema	Yes	No	
Haemophilia	Yes	No	
Cancer	Yes	No	
Limitation of body movement/arthritis	Yes	No	
Prone to keloid scarring	Yes	No	
Hormone imbalance	Yes	No	
Stroke	Yes	No	
Claustrophobia	Yes	No	
Hepatitis	Yes	No	
Metal plates/pins/piercings	Yes	No	
Recent scar tissue/surgery	Yes	No	
Respiratory problems	Yes	No	
Allergies	Yes	No	
Are you pregnant? (female)	Yes	No	
Epilepsy	Yes	No	
High/low blood pressure	Yes	No	
Operations within 6 months	Yes	No	
Any other medical conditions/ailments?	Yes	No	Please specify:

Medication/Treatments			**Additional information**
Steroids	Yes	No	
Recent Botox or fillers?	Yes	No	
Ultra violet exposure	Yes	No	
Laser/IPL	Yes	No	
Retinol or Roaccutane	Yes	No	
Products containing fruit acids	Yes	No	
Microdermabrasion	Yes	No	
Any other medications?	Yes	No	Please specify:

Please provide Doctor's name/address if you answered YES to any of the above:_____
_____

*Please note it is **your** responsibility to bring to our attention any medical conditions or medication you are taking that Could affect your treatment with us and to consult your doctor and produce a letter if you are unsure thank you. This consultation form will be kept if you answered yes to any of the above,please inform us if details change. (Name, phone numbers and email will be kept on our computer for our use only and will not be shared)*

I declare that the above information I have given concerning my health and medication is correct.
(Please note client consultation forms are confidential and personal information will only be used by Karen's beauty rooms for promotional purpose and appointment confirmation.)

Date: Signature: