CLIENT RECORD AND CONSULTATION CARD

PERSONAL AND MEDICAL INFORMATION

Title:	Full Name:	Date of Birth: / /
Address:		Postcode:
Email Address:		Contact Number:
Doctor's Name and Address:		
Next of Kin:	Relation:	Contact Number:

Please answer the following questions. Be as accurate as possible and answer all questions to assist your lash technician for a safe and effective treatment.

Are you taking any medication?	Yes / No
Are you receiving any treatments from your GP?	Yes / No
Do you have any allergies?	Yes / No
Are you pregnant or breast feeding?	Yes / No
Do you suffer from epilepsy or any form of seizures?	Yes / No
Have you had any recent surgery to the eye area?	Yes / No

Do you suffer from any of the following?

Conjunctivitis / Sties	Yes / No	Eczema	Yes / No
Dry Eye syndrome	Yes / No	Cataract	Yes / No
Dermatitis	Yes / No	Glaucoma	Yes / No
Blepharitis	Yes / No	Claustrophobia	Yes / No
Psoriasis	Yes / No	Hayfever	Yes / No

Notes: _____

DATA PROTECTION & CONSENT

The data captured on this record card is to ensure I can safely perform treatments on you and contact you should I need to regarding your appointments. The data will be stored in compliance to the General Data Protection Regulation and kept for 7 years in line with my legal obligations. The data will not be shared with any 3rd party. You may request to opt out and withdraw consent at anytime by writing to me directly, however I will no longer be able to perform treatments on you. Please circle each method of correspondence to confirm that you are happy for me to make contact with you should I need to discuss your appointment.

Telephone Yes / No Messenger Yes / No Social Media Yes / No No Contact Yes / No

Please circle either yes or no to consent for me to use photos of you on my social media platforms. Yes / No

I can confirm that I have completed this form to the best of my knowledge and understand that if there are any changes, I will make my lash technician aware before another treatment is carried out.

Client Signature: _____ Name: _____ Date: _____

Lash Artist Signature: _____ Name: _____ Date: _____

LASHBASE

LASH MAP

LEFT

RIGHT

EYE SHAPE: _____

CURL: _____ THICKNESS: _____

LENGTHS: _____

CLASSIC ☐ VOLUME ☐ HYBRID ☐

FULL SET COST: _____ INFILL COST: _____

NOTES

TREATMENT RECORD

DATE	TREATMENT