EYELASH EXTENSION INTAKE & CONSENT FORM

CLIENT INFORMATION

Full Name:		
Address:		
City:	Post Code:	DOB:
Phone:	Email:	

How did you hear about us?					
Have you had lash extensions before?	☐ Yes	☐ No	Do you wear glasses?	☐ Yes	☐ No
Have you had any recent eye surgery?	☐ Yes	☐ No	Do you wear contacts?	☐ Yes	☐ No

PLEASE TICK IF YOU HAVE ANY OF THE FOLLOWING CONDITIONS:

☐ Skin disease	☐ Glaucoma	☐ Conjunctivitis	☐ Hay Fever	☐ Back/Neck Injury
☐ Psoriasis	☐ Eye infections	☐ Dry Eyes	☐ Diabetes	☐ Pregnant
☐ Eczema	☐ Cataract	☐ Alopecia	☐ Cancer	☐ Other: ________
☐ Cysts	☐ Styes			

Do you have any allergies or disorders that you are aware of? ☐ Yes ☐ No

If Yes, Please list

CLIENT DECLARATION:

Has the treatment been explained to you?	☐ Yes	☐ No
Do you consent to photos of your lashes being taken which may be used on social media or our website?	☐ Yes	☐ No

To the best of my knowledge and ability, I have filled out this form accurately and I will inform the technician promptly if any of the information above changes.

I confirm that I do not have any underlying medical condition(s) that would render the treatment unsuitable.
In the event of any discomfort during the procedure, I will notify the technician immediately so that they can make any necessary adjustments.

I fully understand and accept the potential risks associated with having eyelash extensions & consent to the service.

I agree to follow the aftercare advice provided to me by the technician.
This agreement is valid for this procedure and all future procedures performed by my technician.

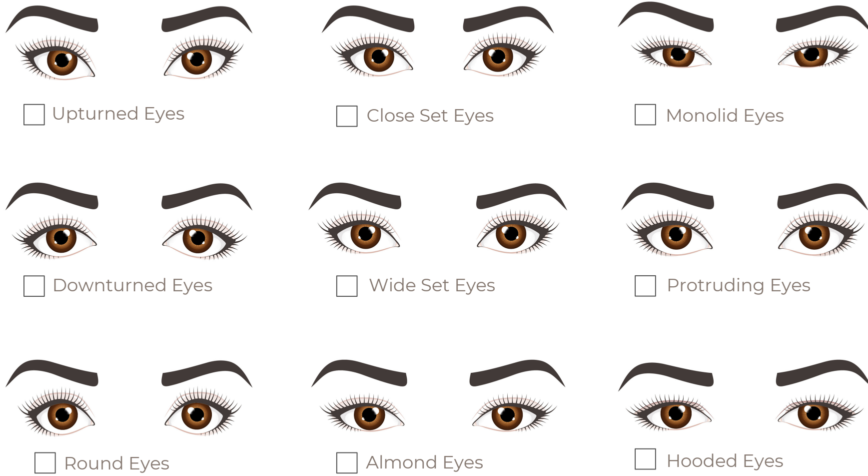
Name: ____________ **Signed:** ____________ **Date:** ____________

NOTES (SALON USE ONLY)

EYELASH EXTENSION CLIENT CONSULTATION FORM

Full Name: ______________________________

EYE SHAPE CHART



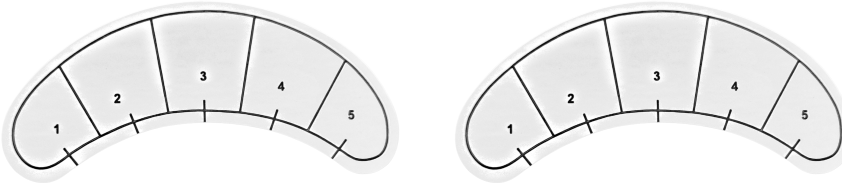
APPLICATION TYPE

- ☐ Classic
- ☐ Hybrid
- ☐ Volume
- ☐ Mega Volume

LENGTH(S)

☐ 6	☐ 7	☐ 8
☐ 9	☐ 10	☐ 11
☐ 12	☐ 13	☐ 14
☐ 15	☐ 16	

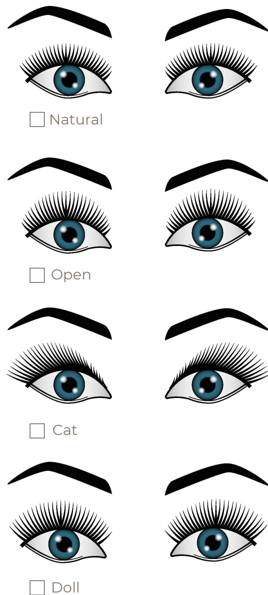
LASH MAP



CURL(S)

☐ B	☐ C	☐ CC
☐ D	☐ DD	☐ U
☐ L	☐ L+	☐ M
☐ Other		

LASH STYLE CHART



DIAMETER(S)

☐ .03	☐ .05	☐ .07	☐ .10	☐ .12	☐ .15
☐ .18	☐ .20				

NOTES

CLIENT RECORDS: EYELASH EXTENSIONS

Full Name: ______________________________

DATE	SERVICE	STYLE	DIMENSION	CURL	DIAMETER	LENGTH	NOTES
	☐ Full Set ☐ Infill ☐ Removal						
	☐ Full Set ☐ Infill ☐ Removal						
	☐ Full Set ☐ Infill ☐ Removal						
	☐ Full Set ☐ Infill ☐ Removal						
	☐ Full Set ☐ Infill ☐ Removal						
	☐ Full Set ☐ Infill ☐ Removal						
	☐ Full Set ☐ Infill ☐ Removal						
	☐ Full Set ☐ Infill ☐ Removal						
	☐ Full Set ☐ Infill ☐ Removal						
	☐ Full Set ☐ Infill ☐ Removal						

LASH LIFT/BROW LAMINATION/TINT INTAKE & CONSENT FORM

CLIENT INFORMATION

Full Name:		
Address:		
City:	Post Code:	DOB:
Phone:	Email:	

How did you hear about us?

Have you had any of the following procedures before? ☐ Lash Lift ☐ Brow Lamination ☐ Lash Tint ☐ Brow Tint

Have you had lash extensions before?	☐ Yes ☐ No	Do you wear glasses?	☐ Yes ☐ No
Have you had any recent eye surgery?	☐ Yes ☐ No	Do you wear contacts?	☐ Yes ☐ No

PLEASE TICK IF YOU HAVE ANY OF THE FOLLOWING CONDITIONS:

☐ Skin disease	☐ Glaucoma	☐ Conjunctivitis	☐ Hay Fever	☐ Back/Neck Injury
☐ Psoriasis	☐ Eye infections	☐ Dry Eyes	☐ Diabetes	☐ Pregnant
☐ Eczema	☐ Cataract	☐ Alopecia	☐ Cancer	☐ Other: ________
☐ Cysts	☐ Styes			

Do you have any allergies or disorders that you are aware of? ☐ Yes ☐ No

If Yes, Please list

CLIENT DECLARATION:

Has the treatment been explained to you?	☐ Yes ☐ No
Do you consent to photos of your lashes being taken which may be used on social media or our website?	☐ Yes ☐ No

To the best of my knowledge and ability, I have filled out this form accurately and I will inform the technician promptly if any of the information above changes.

I confirm that I do not have any underlying medical condition(s) that would render the treatment unsuitable.
In the event of any discomfort during the procedure, I will notify the technician immediately so that they can make any necessary adjustments.

I fully understand and accept the potential risks associated with having eyelash extensions & consent to the service.

I agree to follow the aftercare advice provided to me by the technician.
This agreement is valid for this procedure and all future procedures performed by my technician.

Name: ______________ Signed: ______________ Date: ______________

NOTES (SALON USE ONLY)

CLIENT RECORDS: LASH LIFT/BROW LAMINATION/TINT

Full Name: ______________________________

DATE	PROCEDURE(S)	SHIELD SIZE	PROCESSING TIMES	NOTES
		☐ Small ☐ Medium ☐ Large	Lift/Lam: ________ Neutralising: ________ Tinting: ________	
		☐ Small ☐ Medium ☐ Large	Lift/Lam: ________ Neutralising: ________ Tinting: ________	
		☐ Small ☐ Medium ☐ Large	Lift/Lam: ________ Neutralising: ________ Tinting: ________	
		☐ Small ☐ Medium ☐ Large	Lift/Lam: ________ Neutralising: ________ Tinting: ________	
		☐ Small ☐ Medium ☐ Large	Lift/Lam: ________ Neutralising: ________ Tinting: ________	
		☐ Small ☐ Medium ☐ Large	Lift/Lam: ________ Neutralising: ________ Tinting: ________	
		☐ Small ☐ Medium ☐ Large	Lift/Lam: ________ Neutralising: ________ Tinting: ________	
		☐ Small ☐ Medium ☐ Large	Lift/Lam: ________ Neutralising: ________ Tinting: ________	
		☐ Small ☐ Medium ☐ Large	Lift/Lam: ________ Neutralising: ________ Tinting: ________	