

**CLIENT INFORMATION****EYELASH EXTENSION INTAKE & CONSENT FORM**

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

How did you hear about us?		
Have you had lash extensions before?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you wear glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had any recent eye surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you wear contacts? <input type="checkbox"/> Yes <input type="checkbox"/> No

**PLEASE TICK IF YOU HAVE ANY OF THE FOLLOWING CONDITIONS:**

<input type="checkbox"/> Skin disease	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Conjunctivitis	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Back/Neck Injury
<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Eye infections	<input type="checkbox"/> Dry Eyes	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Pregnant
<input type="checkbox"/> Eczema	<input type="checkbox"/> Cataract	<input type="checkbox"/> Alopecia	<input type="checkbox"/> Cancer	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Cysts	<input type="checkbox"/> Styes			

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

*If Yes, Please list*

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**CLIENT DECLARATION:**

Has the treatment been explained to you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you consent to photos of your lashes being taken which may be used on social media or our website?	<input type="checkbox"/> Yes <input type="checkbox"/> 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)**

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