Client Consult/Consent - Lash Extension

Name:_____ Date _____

Address:_____ City:_____ State: _____ Zip:_____

Phone: _____ Date of Birth:_____ Occupation:_____

Email Address: _____ How did you hear of us?_____

Would you like to receive my monthly newsletter/Hear about specials and events? No ☐ Yes ☐

Emergency contact:_____ Phone:_____ Relationship to you:_____

Health History

Please list any allergies you have (including cosmetics/ingredients):_____

_____

Are you allergic to Acrylate/Cyanocarylate (bonding agent)? ☐Yes ☐No ☐Don't Know
Have you had a reactions to adhesive tape, topical creams, or other topical products? ☐Yes ☐No
Do you have eye disease, condition or injury that affects your hair/lash growth or loss? ☐Yes ☐No

List all current medications you are taking (including over-the-counter herbs, vitamins, supplements): _____

_____

Have you ever had any of these conditions? (Please check)

Alopecia ☐	Asthma ☐	Back pain/injury ☐	Bell's Palsy ☐	Blepharitis ☐	Claustrophobia ☐
Cold Sores ☐	Pink Eye ☐	Diabetes ☐	Dry Eye Syndrome ☐	Eye Sties or Sores ☐	Herpes of the Eye ☐
Intense Stress ☐	Leamy eye ☐	Light Sensitivity ☐	Migraines ☐	Ocular Rosacea ☐	Rosacea ☐
Sensitive Eyes ☐	Stroke/TIA ☐	Thyroid Disease ☐	Trichotillomania ☐	Recent Eye Surgery ☐	Current Eye Irritation ☐

Any other health condition not listed:_____

These questions are relevant to your hair growth, and overall hair health. Please answer as fully as possible.

Question	Y	N	Details	Adverse Reactions?
Are you pregnant or nursing?	○	○		
Do you wear contacts?	○	○		
Do you wear glasses?	○	○		
Have you ever had lash extensions?	○	○		
Have you ever had lash extensions removed?	○	○		
Have you ever used long lasting or waterproof cosmetics?	○	○		
Do you use Retin-A or Accutane?	○	○		
Do you go tanning (in salon, outdoor, or spray tan)?	○	○		
Have you had facial treatments?	○	○		
Have you ever had Botox®, Juvederm®, or other injectables?	○	○		
Have you ever used Latisse® or other lash growing product?	○	○		

Which side do you most often sleep on? ☐Right ☐Left ☐Stomach ☐Back
How fast do you feel your hair grows? ☐Fast ☐Slow ☐Normal Rate

Is there anything else we should know about?_____

Although every precaution will be taken to ensure your safety and wellbeing before, during and after your lash extension application, please be aware of the following information and possible risks. Please initial:

___ I understand that a full set of lash extensions can make the appearance of my own lashes about 30-50% thicker, and make my lashes appear 20-50% longer.

___ I understand that lash extension services have some inherent risk of irritation to the orbital eye area, including the eye itself, and could result in **stinging and burning**, **blurry vision** and **potential blindness** should the adhesive enter the eye or should an allergic reaction occur.

___ I understand that some irritation, itching or burning may occur on the skin if the bonding agent comes into contact with it.

___ I understand that if the bonding agent comes into contact with my eye, my eye will be flushed with water and I will be assisted in seeking medical attention immediately.

___ I understand that this is a semi-permanent procedure, as my natural lashes will continue to grow and fall out normally, making touch-up or "fill" appointments necessary to maintain the original look achieved by replacing the lashes that have fallen out. Most clients require a fill appointment every 2-3 weeks.

___ I understand that while every attempt will be made to provide me with the length and fullness I have chosen, my final result may not be what I initially envisioned.

___ I understand that it is imperative that I disclose all of the information requested in the Client Profile/Health History.

___ I have cited all conditions and circumstances regarding my health history, medications being taken, and any past reactions to products or medications.

___ I understand that additional conditions could occur or be discovered during the procedure which could affect my ability to tolerate the procedure.

___ I consent to "before and after" photographs for the purpose of monitoring treatment effects, documentation, potential advertising and promotional purposes.

I understand that any information provided is to aid the service professional in giving better service and is completely confidential. I understand, have read and completed this questionnaire honestly and truthfully. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. I agree to keep the service provider updated to any changes in my medical profile and understand that there should be no liability on the service providers part should I fail to do so. I give permission to my skin care specialist to perform treatment we have discussed, and will hold him/her and his/her staff harmless and nameless from any liability that may result from this treatment. I understand my skin care specialist will take every precaution to minimize or eliminate negative reactions as much as possible. If I experience any discomfort or pain during the session, I will immediately inform the service professional. In the event I may have additional questions or concerns regarding my treatment, I will consult the skin care specialist immediately. I understand that the services offered are not a substitute for medical care. I also understand that the service provided, and advice of the provider should not be construed as a substitute for a medical examination, diagnosis, or treatment and that I should see a medical professional for any mental or physical ailment I am aware of. I understand the service professional is not qualified to diagnose, prescribe, or treat any skin disease or disorder and nothing said during the course of the appointment be construed as such. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read, and fully understand, the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered. I understand the procedure and accept the risks. I do not hold the skin care specialist responsible for any of my conditions that were present, but not disclosed at the time of this procedure, which may be affected by the treatment performed today. By signing below, I hereby authorize Bliss by Sherise to administer treatment services to me, and will hold Bliss by Sherise or its service providers harmless from any liability that may result from this treatment. I release this institution and/or skin care professional from liability and assume full responsibility thereof.

Client Signature_____Date:_____

SUBMIT