CLIENT INTAKE FORM FOR EYELASH EXTENSIONS

Date :

CLIENT EYELASH EXTENSION INTAKE FORM

First Name :

Phone :

Date Of Birth : D D M M Y Y

Full Address :

City/State :

Postal Code :

E-Mail :

City / Country :

How did You Hear About US :

Referral :

Type of Service Today : ☐ Classic ☐ Hybrid ☐ Volume ☐ Mega ☐ Strip Lashes/Textured

HEALTH HISTORY

Cancer (Skin or Other)	☐ Yes	☐ No	Infection (Virus, Bacteria)	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Eye Disorders	☐ Yes	☐ No
Autoimmune Disease (lupus, RA, MS etc.)	☐ Yes	☐ No	Chronic Pain (Migraine, etc.)	☐ Yes	☐ No
Thyroid Disease	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No
Neck/Back Pain	☐ Yes	☐ No	Hormone Issues (Menopause)	☐ Yes	☐ No
Heart Problems/ Blood Pressure	☐ Yes	☐ No			
Allergies (Please List)	☐ Yes	☐ No			

Explanation/Further Details: _____

_____

_____

SKIN HISTORY

Recent surgery (general) the last 6 months?	☐ Yes	☐ No
Recent cosmetic surgery the last 6 months?	☐ Yes	☐ No
Recent cosmetic injections (Botox, Fillers, etc.) ?	☐ Yes	☐ No
Recent hair removal ? (Waxing, Laser, Electrolysis)	☐ Yes	☐ No
Are you under a doctors care for skin issues?	☐ Yes	☐ No
Laser Treatments/IPL within the last month?	☐ Yes	☐ No
Chemical peels within the last month?	☐ Yes	☐ No
Recent sunburn?	☐ Yes	☐ No

DAILY MEDICATIONS

☐ Antibiotic	☐ Antidepressant	☐ Diabetes	☐ Thyroid
☐ Sleep/Anxiety	☐ Pain/NSAIDS	☐ Heart/Blood Pressure	☐ Anti-Androgen
☐ Hormones	☐ Skin Disease	☐ Other:	

EYELASH EXTENSIONS

Have you ever had eyelash extensions?	☐ Yes	☐ No
Have you ever had an adverse reaction to acrylate/cyanoacrylate?	☐ Yes	☐ No
Have you ever had an adverse reaction to adhesive tape, nail adhesives or topical products?	☐ Yes	☐ No

Although every precaution will be made to ensure your safety and well-being before, during and after your tinting application, please be aware of the possible risk below. Please initial:

_____ I understand that eyelash extensions has some inherent risk or irritation to the orbital area, including the eye itself, and could result in stinging or burning, blurry vision and potentially blindness should the adhesive enter into the eye.

_____ I understand that if the adhesive, primer, or other solutions accidently comes into contact with my eye, my eye will be flushed with water and medical attention may be required.

_____ I understand that some irritation, itching or burning may occur to the skin or eyes that comes in contact with the adhesive and other lash related products.

_____ I understand that there may be some residual of the eyelash products left on the skin following the lash application of either my eyes or skin. The irritation or sensitivities will go away within a short time.

_____ I understand that, while every attempt will be made to provide me with my chosen style, everyone's face or body part is not symmetrical and my final results may not be what I initially wanted.

_____ I understand that over the course of several weeks, I will lose 1-5 eyelashes everyday. Fills will be required to keep the eyelash extensions fresh. Most clients need a fill every 2-4 weeks.

FUTURE APPOINTMENTS/CONTACT

May I call you at your phone number to confirm future appointments?	☐ Yes	☐ No
May I text you to confirm?	☐ Yes	☐ No
May I contact you via mail/email about future promotions and news?	☐ Yes	☐ No

SERVICE CONSENT

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that is supersedes and previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin or eye area from treatments received. I understand the appointment cancellation policy. The treatments I receive here are voluntary, and I release this institution and/or skin care professional/ lash technician from liability and assume full responsibility thereof.

Client Signature: _____ Date: _____