

Consultation Sheet / Treatment _____ Therapist Name _____

Client Name:
Date of Birth:
Address:
Contact number:
E-mail address:

MEDICAL DETAILS

Client taking steroids	Acne/Acne medication	Circulatory Disorder
Diabetes	Sensitive skin	Heart Condition
Epilepsy	Dermatitis	Varicose Veins
Asthma	Broken Capillaries	Thrombosis
Stress/ Anxiety, Depression	Wear contact lenses	High/Low Blood Pressure
Pregnancy: Months	Sinus problem	Haemorrhage/Swelling
Breast feeding	Scar Tissue	Bruising
	Skin Disorder	Cancer
Dysfunction of Nervous System	Recent surgery	Headaches / Migraine
Allergies	Eczema / Psoriasis/ Dermatitis	Braces/retainers
Cold sores	Hormonal condition	Thyroid condition
Keloid scaring or prone to keloid scaring	Are you taking blood thinners? Fish oils/plant oils/omega 3's Ginseng/St Johns Wart	Allergies to products:

Current Medication/treatment

In the last 3 months have you had in the area to be treated today		In the last 2 weeks have you had in the area to be treated today?	
Plastic/cosmetic surgery		Electrolysis/diathermy	
Laser/IPL rejuvenation/hair removal		Shaving/Waxing/Plucking/ Depilatory creams	
Dermabrasion		Self-tanning	
Photo dynamic therapy (PDT)		Chemical peels- including home treatments including AHA's,	
Dermal fillers			
Muscle relaxant injections			
Tattooing/cosmetic tattooing			

I agree that all the information provided above is correct:

Client signature _____ Date: _____

LIFESTYLE

Client occupation-
Do you smoke?
Describe your eating habits.
Do you drink alcohol?
How much water, on average, do you drink daily?
Which caffeinated drinks do you normally consume?
Do you sunbathe or use tanning beds?
Do you wear a SPF daily?
Which of the following best describes your skin type on the Fitzpatrick scale? 1. I Creamy complexion – Always burns, never tans 2. II Light Complexion – Always burns, tans slightly 3. III Light/Matte Complexion - burns moderately, tans gradually 4. IV Matte Complexion – rarely burns – always tans well 5. V Brown Complexion – rarely burns, deep tan 6. VI Black Complexion - Never burns, deeply pigmented
Have you had a facial treatment before?

TREATMENT OBJECTIVES

1. What is your current skin care routine?

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2. Why have you booked the treatment today (client's objectives)?

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3. Do you have any specific concerns you would like me to focus on?

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TREATMENT PLAN MEETING THE CLIENTS NEEDS (include products that you plan to use)

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ANY MODIFICATIONS

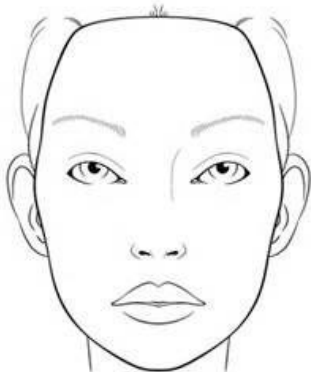
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CLIENT DECLARATION

I confirm that the above information is correct and understand the treatment plan prescribed for me and I am happy to proceed with the treatment

Client signature_____

SKIN ANALYSIS

Skin type	Elasticity		Notes-
Redness	Pigmentation		
Skin texture	Broken capillaries		
Muscle tone	Fine/deep lines		
Congestion	Dehydration		

IMMEDIATE AFTERCARE ADVICE

Drink water	Avoid UV
Avoid heat treatments	Avoid make-up
Avoid swimming	Avoid Exercise
No cleansing the skin for a minimum of 6 hours	Avoid applying products

SPECIFIC TREATMENT RELATED ADVICE:**FUTURE TREATMENT RECOMMENDATIONS****PRODUCT RECOMMENDATIONS****POSSIBLE CONTRA-ACTIONS AND ACTION TO BE TAKEN****CLIENT FEEDBACK (please could you provide some feedback about your treatment today)**

Client signature _____

STUDENT EVALUATION (include what went well, what didn't go as well, areas for improvement, things you would do differently, action plan for next treatment)

Student signature _____ Date _____

Case study number _____

Consent Form



- I understand that photographs are essential for insurance purposes.
- I consent to my photographs being used for marketing purposes **Yes / No**
- I consent to Enhance Me contacting me in future for opportunities to be a model **Yes / No**
- I understand that Enhance Me will securely store the data I have written on this form, not share with it any third parties, and that I can request a copy or for it to be deleted at any time.
- I understand that microneedling is a revolutionary collagen induction treatment which induces a 'controlled injury to the skin' causing collagen and elastin fibers to be stimulated and re produced.
- I understand that my face will be slightly red post treatment. I understand that there is a risk of blood spots and slight swelling.
- I understand that there must be at least 3-4 weeks between Microneedling treatments.
- I understand that I need to use a high factor sunscreen on my face for at least 1 week post treatment as my skin will be sun sensitive and to avoid pigmentation occurring.
- I consent to the use of other products as part of this treatment i.e. cleansers, post treatment creams and sunscreen.
- I confirm that I have given medical information to the best of my knowledge and not withheld any information.
- I consent to having before and after photographs taken
- I understand that photographs are essential for insurance purposes.
- I consent to my photographs being used for marketing purposes **Yes / No**
- I consent to my photographs being used for social media and marketing purposes **Yes / No**
- I therefore give consent to the described treatment.

Name: _____

Signature: _____ Date: _____