**Client Consultation Form – *Laser & Intense Pulsed***

***Light Treatments***

**College Name:**

**College Number:**

**Student Name:**

**Student Number:**

**Date:**

**Client Name:**

**Address:**

**Profession:**

**Tel. No:** Day

 Eve

**PERSONAL DETAILS**

**Age group:** Under 20[ ]  20–30[ ]  30–40[ ]  40–50[ ]  50–60[ ]  60+[ ]

**Lifestyle:** Active**[ ]** Sedentary**[ ]**

**Last visit to the doctor:**

**GP Address:**

**No. of children (if applicable):**

**Date of last period (if applicable):**

## CONTRAINDICATIONS REQUIRING MEDICAL REFERRAL OR THE CLIENT TO INDEMNIFY THEIR CONDITION IN WRITING PRIOR TO TREATMENT (*select if/where appropriate):*

Any condition already being treated by a GP, dermatologist or another skin therapist

Medical oedema

Osteoporosis

Arthritis

Nervous/Psychotic conditions

Recent operations

Diabetes

Asthma

Bells Palsy

Trapped/Pinched nerve

Inflamed nerve

Acute rheumatism

**CONTRAINDICATIONS THAT RESTRICT TREATMENT (*select if/where appropriate):***

Fever [ ]

Contagious or infectious diseases [ ]

Under the influence of drugs or alcohol [ ]

Cancer [ ]

Pregnancy [ ]

Drugs or medications that cause photo-sensitisation or skin thinning effects [ ]

Herbal remedies that cause photo-sensitisation [ ]

Allergies to the products or materials used [ ]

Epilepsy [ ]

Cardio-vascular conditions (thrombosis, phlebitis, hypertension, hypotension, heart conditions) [ ]

Connective tissue disorders (scleroderma) [ ]

Herpes [ ]

Skin diseases [ ]

Undiagnosed lumps and bumps [ ]

Cuts [ ]

Bruises [ ]

Abrasions [ ]

Sunburn [ ]

Suntanned skin [ ]

Artificial tan until the product has faded from the skin [ ]

Areas of undiagnosed pain [ ]

Skin pigment conditions (vitiligo, melasma moles and pigmented naevi) [ ]

Keloid scars [ ]

Any metal pins or plates [ ]

Loss of skin sensitivity (test with tactile and thermal methods) [ ]

**TREATMENT**:

Hair removal [ ]

Skin Rejuvenation [ ]

Pigmentation [ ]

Diffused redness [ ]

**SUN EXPOSURE IN THE LAST 30 DAYS:** YES [ ]  NO [ ]

**PATCH TEST:** Date:      Area:

**PATCH TEST REACTION:**

**MEDICAL HISTORY:**

**AREA TO BE TREATED (*select if/where appropriate)*:**

**Face:**

Upper lip [ ]

Chin [ ]

Cheeks [ ]

Neck [ ]

Side Burns [ ]

Hairline [ ]

Jaw line [ ]

**Body:**

Underarms [ ]

Bikini line [ ]

Shoulders [ ]

Upper arms [ ]

Chest [ ]

Forearms [ ]

Back [ ]

Buttocks [ ]

Thighs [ ]

Lower leg [ ]

Abdomen [ ]

Hands [ ]

**PREVIOUS TREATMENT (*select if/where appropriate)*:**

Waxing [ ]

Threading [ ]

Tweezing [ ]

Depilatory cream [ ]

Bleaching [ ]

Shaving [ ]

Epilation [ ]

Sugaring [ ]

Cosmetic surgery [ ]

Micro pigmentation [ ]

Microdermabrasion [ ]

[ ]

**Date of previous treatment:**

**Any reaction to previous treatment:** YES [ ]  NO [ ]

If yes please state reaction:

**SKIN TYPE:**

I [ ]

II [ ]

III [ ]

& Ethnic Skins [ ]

**SKIN TYPE DETAILS:**

**SKIN CONDITION:**

Pigmentation [ ]

Area:

Skin rejuvenation [ ]

Area:

Diffused redness [ ]

Area:

**HAIR CONDITION:**

Hirsutism [ ]

Hypertrichosis [ ]

Superfluous hair [ ]

**Informed Consent:** YES [ ]  NO [ ]

**Photographic evidence:** YES [ ]  NO [ ]

**Treatment details*(to include skin cooling method and parameters)*:**

**Reaction during treatment:**

**Client feedback:**

**Aftercare and Home care advice:**

**Therapist signature……………………………………**

**Client signature…………………………………………**

**Date…………………..**