**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:** ActiveSedentary

**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

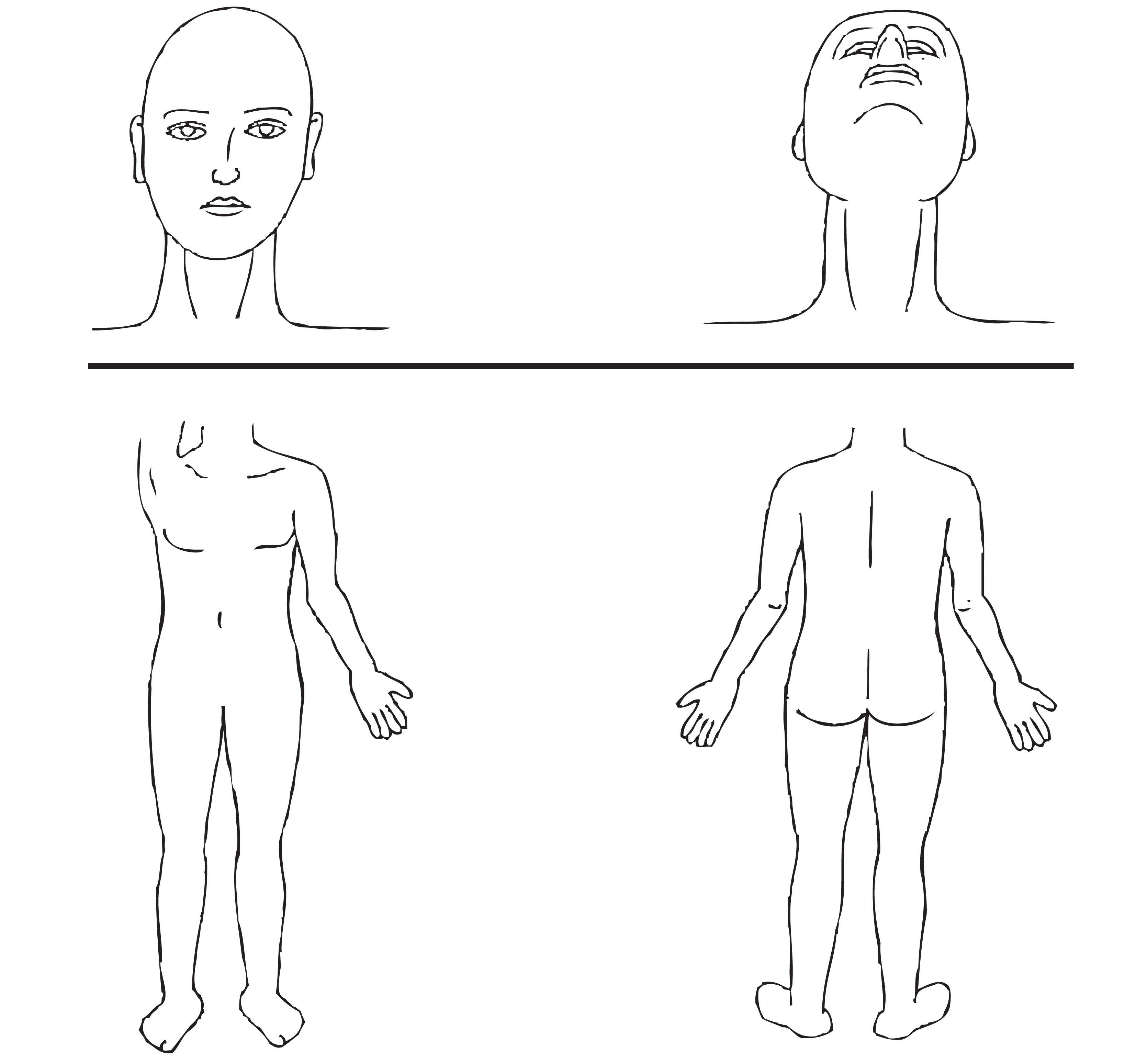
Buttocks

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…………………..**