Client Consultation Form

iUBT290 – Skin care and eye treatments

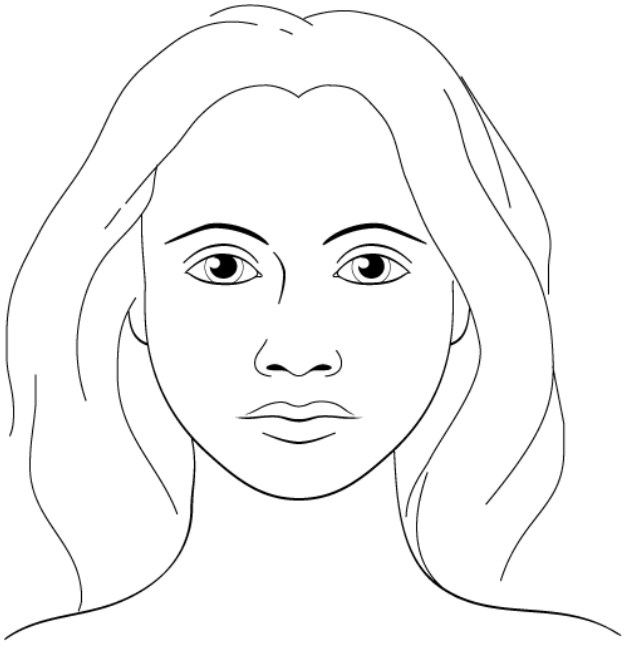
Centre name:	
Centre number:	
Learner name:	
Learner number:	
Date:	

Client name:		
Address:		
Profession:		
Telephone number:	Day:	
	Evening:	

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:						
Number of children: *(If applicable)*						
Date of last period: *(If applicable)*						

Contra-indications requiring medical permission – *In circumstances where medical permission cannot be obtained clients must give their informed consent in writing prior to treatment (Select if/where appropriate):*					
Medical oedema	☐	Nervous/psychotic conditions	☐	Epilepsy	☐
Recent facial operations affecting the area	☐	Diabetes	☐	Skin cancer	☐
Slipped disc	☐	Undiagnosed pain	☐	When taking prescribed medication	☐
Whiplash	☐				

Contra-indications that restrict treatment – *(Select if/where appropriate):*					
Fever	☐	Contagious or infectious diseases	☐	Under the influence of recreational drugs or alcohol	☐
Diarrhoea and vomiting	☐	Any known allergies	☐	Eczema	☐
Undiagnosed lumps and bumps	☐	Localised swelling	☐	Inflammation	☐
Cuts	☐	Bruises	☐	Abrasions	☐
Scar tissues (2 years for major operation and 6 months for a small scar)	☐	Sunburn	☐	Conjunctivitis	☐
Hormonal implants	☐	Recent fractures (minimum 3 months)	☐	Sinusitis	☐
Neuralgia	☐	Migraine/Headache	☐	Hypersensitive skin	☐
Botox/dermal fillers (1 week following treatment)	☐	Hyper-keratosis	☐	Skin allergies	☐
Styes	☐	Watery eyes	☐	Trapped/pinched nerve affecting the treatment area	☐
Inflamed nerve	☐	Eye infection	☐		

Skin test – *(Select if/where appropriate):*				
Moisture content:	Excellent ☐	Good ☐	Fair ☐	Poor ☐
Muscle tone:	Excellent ☐	Good ☐	Fair ☐	Poor ☐
Elasticity:	Excellent ☐	Good ☐	Fair ☐	Poor ☐
Sensitivity:	High ☐	Medium ☐	Low ☐	
Skins healing ability:	Excellent ☐	Good ☐	Fair ☐	Poor ☐
Skin tone:	Fair ☐	Medium ☐	Dark ☐	Olive ☐
Circulation:	Good ☐	Normal ☐	Poor ☐	
Pores:	Fine ☐	Dilated ☐	Comedones ☐	Milia ☐
Overall skin type:				
Treatment to include *(Select where appropriate):*	Superficial cleanse ☐	Deep cleanse ☐	Pre-heat treatment ☐	Skin analysis ☐
	Lash tinting ☐	Brow tinting ☐	Eyebrow tweezing ☐	Massage ☐
	Mask ☐			
				

Treatment details – *(To include products used):*

Client feedback:

Aftercare/Home care advice given:

Therapist/Learner signature: _____

Client signature: _____

Document History

Version	Issue Date	Changes	Role
v1	03/09/2019	First published	Qualifications and Regulation Coordinator