Client Consultation Form

iUBT396 – Apply airbrush make-up to the face

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):*					
Any skin condition being treated by a dermatologist	☐	Inflamed nerve	☐	Skin cancer	☐
Nervous/psychotic conditions	☐	Bell's palsy	☐	Undiagnosed pain in the face	☐
Medical oedema	☐	Epilepsy	☐	Diabetes	☐
Recent facial operations	☐	Whiplash	☐		

Contra-indications that restrict treatment – *(Select if/where appropriate):*					
Fever	☐	Sunburn	☐	Very nervous clients	☐
Contagious or infectious diseases	☐	Recent fractures (minimum 3 months)	☐	Blepharitis	☐
Under the influence of recreational drugs or alcohol	☐	Sinusitis	☐	Eczema	☐
Any known allergies	☐	Neuralgia	☐	Psoriasis	☐
Infectious skin diseases and disorders	☐	Sunburn	☐	Dermatitis	☐
Undiagnosed lumps and bumps	☐	Migraine/headache	☐	Sycosis barbae	☐
Localised swelling	☐	Hypersensitive skin	☐	Botox/dermal fillers (1 week following treatment)	☐
Inflammation	☐	Conjunctivitis	☐	Herpes simplex	☐
Cuts	☐	Any eye surgery (approximately 6 months)	☐	Seborrheic dermatitis	☐
Bruises	☐	Stye	☐	Urticaria	☐
Abrasions	☐	Watery eye	☐	Temporomandibular joint tension (TMJ syndrome)	☐
Hyperkeratosis	☐	Skin allergies	☐	Chemotherapy	☐
Scar tissue(2 years for major operation and 6 months for a small scar)	☐	Contact lenses must be removed	☐	Diarrhoea and vomiting	☐

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:	White ☐	Black ☐	Asian skin type ☐	Mixed ☐
	Dry ☐	Oily ☐	Combination ☐	Mature ☐
	Young ☐	Brief description:		

Skin sensitivity/patch test – *Documentary evidence of patch test to be included (Select if/where appropriate):*	
Product tested:	
Positive ☐	Negative ☐

Research materials*:*

Design details/specification – *(Clear explanation and instructions of how to create the look):*

Photographs *(Showing progressive shots)*:

Client feedback:

Aftercare feedback:

Therapist/learner signature: _____

Client signature: _____

Skin sensitivity/patch test

Client Information

Please read carefully and only sign if you are in full agreement with its contents

I ---------- confirm that I have received the required patch test (s) 24-48 hours prior to receiving fashion and photographic make-up treatment and confirm that I am willing to proceed.

You should note that if the learner is unable to explain to you the treatment contra-actions and contraindications or is unsure of anything that may apply to a specific condition then they should not treat you without asking you to consult with your GP or Consultant.

It is your responsibility and not that of the learner to consult your GP or Consultant.

I hereby indemnify the learner against any adverse reaction sustained as a result of the treatment

Client's Signature..... Date.....

Learner's Signature..... Date.....

Document History

Version	Issue Date	Changes	Role
v1	14/10/2019	First published	Qualifications Administrator