Client Consultation Form

iUBT380 – Instruction on make-up application

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

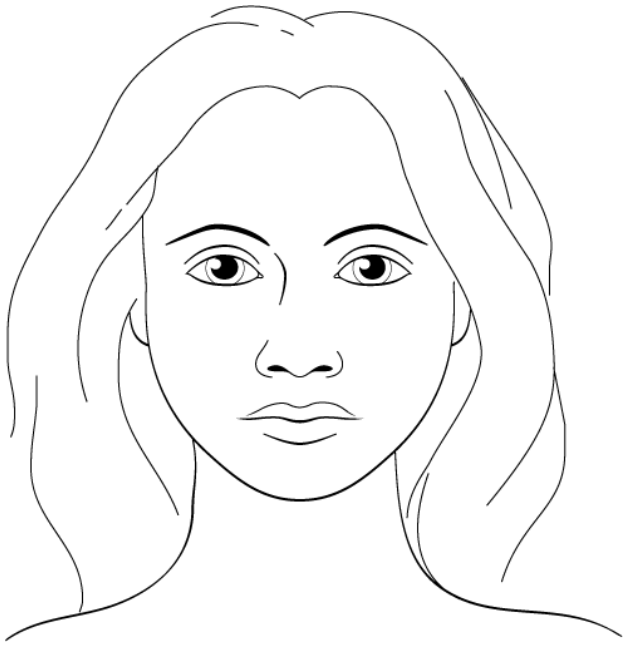
Client name:		
Address:		
Profession:		
Telephone number:	Day:	
	Evening:	

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 ☐	Diabetes ☐	Undiagnosed pain ☐
Nervous/psychotic conditions ☐	Skin cancer ☐	When taking prescribed medication ☐
Epilepsy ☐	Slipped disc ☐	Whiplash ☐
Recent facial operations affecting the area ☐		

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

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 ☐	Olive ☐	Dark ☐
Circulation:	Good ☐	Normal ☐	Poor ☐	
Pores:	Fine ☐	Dilated ☐	Comedones ☐	Milia ☐
Overall skin type:				

Treatment to include *(select where appropriate):*	Day make-up ☐	Bridal make-up ☐	Special occasion make-up ☐
	Evening make-up ☐	Other ☐	
			

Treatment details – *(Select if/where appropriate):*	
Cleanser:	
Toner:	
Moisturiser:	
Pre-base:	
Concealer:	
Foundation:	
Powder:	
Blusher:	
Bronzing products:	
Eyebrow products:	
Eyeshadow:	
Mascara:	
Lip liner:	
Lip products:	
Additional make-up products:	

Client feedback:

Aftercare/home care advice given *(to include products/colours recommended):*

Therapist/learner signature: _____

Client signature: _____

Document History

Version	Issue Date	Changes	Role
v1	29/10/2019	First published	Qualifications Administrator