Client Consultation Form

iUBT335 – Electrical epilation

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):*					
Pregnancy	☐	Medical oedema	☐	Diabetes	☐
Cardiovascular conditions (thrombosis, phlebitis, hypertension, hypotension, heart conditions)	☐	Nervous/psychotic conditions	☐	Asthma	☐
Haemophilia	☐	Epilepsy	☐	Any dysfunction of the nervous system (e.g. multiple sclerosis, Parkinson's disease, motor neurone disease)	☐
Any condition already being treated by a GP or another practitioner	☐	Recent operations	☐	Neuralgia	☐
Inflamed nerve	☐	Cancer	☐	Spastic conditions	☐
Whiplash and any neck conditions	☐	Slipped disc	☐	Undiagnosed pain	☐
When taking prescribed medication	☐	Endocrine disorders	☐		

Contra-indications that restrict treatment – *(Select if/where appropriate):*					
Fever	☐	Keloid scarring	☐	Varicose veins	☐
Contagious or infectious diseases	☐	Skin diseases	☐	Pregnancy (abdomen)	☐
Under the influence of recreational drugs or alcohol	☐	Hairy moles	☐	Cuts	☐
Diarrhoea and vomiting	☐	Undiagnosed lumps and bumps	☐	Bruises	☐
Mucous membranes	☐	Localised swelling	☐	Abrasions	☐
HIV/AIDS	☐	Inflammation	☐	Scar tissues (2 years for major operation and 6 months for a small scar)	☐
Anticoagulant drugs	☐	Hyperpigmentation	☐	Sunburn	☐
Bell's palsy	☐	Botox/dermal fillers (1 week following treatment)	☐	Hormonal implants	☐
Loss of skin sensation	☐	Hypersensitive skin	☐	Abdomen (first few days of menstruation depending how the client feels)	☐
Haematoma	☐	Hernia	☐	Recent fractures (minimum 3 months)	☐
Cervical spondylitis	☐	Metal plates	☐	Mechanical implants	☐

Written permission required by *(Either of which should be attached to the consultation form):*	
GP/specialist ☐	Informed consent ☐

Previous epilation treatments:			
Has the client had any previous epilation treatments?	Yes ☐	No ☐	If yes, for how long?
Result of previous treatment (if applicable)			
Any skin reaction?			

Present hair and skin condition – *(Select if/where appropriate):*		
Normal skin/good healing ☐	Erratic/slow to heal ☐	Sensitive/prone to reaction ☐
Dilated capillaries present ☐	Oily and blocked ☐	Scars present ☐
Subject to blemishes/cysts ☐	Strong/pigmented hair ☐	Prone to pigmentation patches ☐
Dense fine hair ☐	Very dry skin ☐	

Area of treatment – *(Select if/where appropriate):*		
Face ☐	Chest/breast ☐	Bikini line ☐
Abdomen ☐	Underarms ☐	

Method of treatment *(Select if/where appropriate):*	
Short wave diathermy ☐	Blend ☐
Intensity used:	
Machine used:	

Treatment details to include possible reason for hair growth, hair type and reaction to treatment:

Client feedback:

After/home care advice given:

Learner signature: _____

Client signature: _____

iUBT335 – Follow-up Sheet

Treatment details:

Client feedback:

After/home care advice given:

Document History

Version	Issue Date	Changes	Role
v1	09/10/19	First published	Qualifications Administrator
v2	17/12/19	'centre' instead of college and other format changes	Qualifications Administrator