

Client Consultation Form

iUBT390 – The art of photographic make-up

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

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

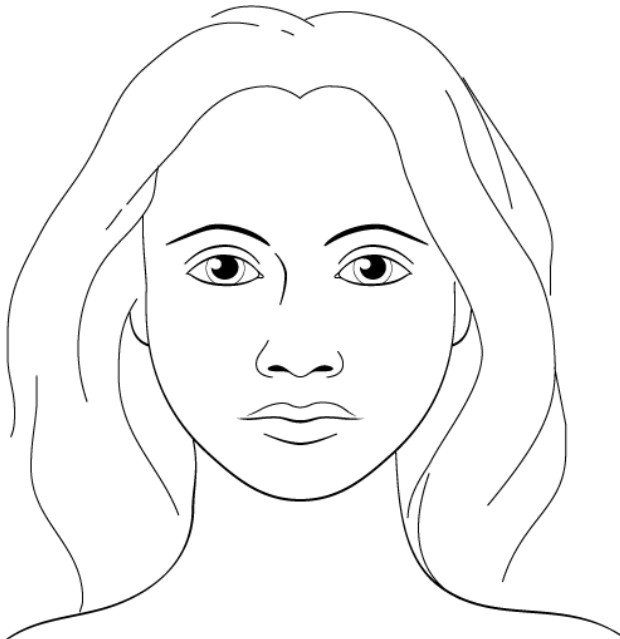
Personal details:						
Age group:	Under 20 <input type="checkbox"/>	20 – 30 <input type="checkbox"/>	30 – 40 <input type="checkbox"/>	40 – 50 <input type="checkbox"/>	50 – 60 <input type="checkbox"/>	60+ <input type="checkbox"/>
Lifestyle:	Active <input type="checkbox"/>			Sedentary <input type="checkbox"/>		
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 <input type="checkbox"/>	Diabetes <input type="checkbox"/>	Undiagnosed pain <input type="checkbox"/>
Nervous/psychotic conditions <input type="checkbox"/>	Skin cancer <input type="checkbox"/>	When taking prescribed medication <input type="checkbox"/>
Epilepsy <input type="checkbox"/>	Slipped disc <input type="checkbox"/>	Whiplash <input type="checkbox"/>
Recent facial operations affecting the area <input type="checkbox"/>		

Contra-indications that restrict treatment – (Select if/where appropriate):

Fever <input type="checkbox"/>	Cuts <input type="checkbox"/>	Hypersensitive skin <input type="checkbox"/>
Contagious or infectious diseases <input type="checkbox"/>	Bruises <input type="checkbox"/>	Botox/dermal fillers (1 week following treatment) <input type="checkbox"/>
Under the influence of recreational drugs or alcohol <input type="checkbox"/>	Abrasions <input type="checkbox"/>	Hyperkeratosis <input type="checkbox"/>
Diarrhoea and/or vomiting <input type="checkbox"/>	Scar tissue (2 years for major operation and 6 months for a small scar) <input type="checkbox"/>	Skin allergies <input type="checkbox"/>
Any known allergies <input type="checkbox"/>	Conjunctivitis <input type="checkbox"/>	Styes <input type="checkbox"/>
Eczema <input type="checkbox"/>	Sunburn <input type="checkbox"/>	Blepharitis <input type="checkbox"/>
Dermatitis <input type="checkbox"/>	Hormonal implants <input type="checkbox"/>	Watery eyes <input type="checkbox"/>
Psoriasis <input type="checkbox"/>	Recent fractures (minimum 3 months) <input type="checkbox"/>	Trapped/pinched nerve affecting the treatment area <input type="checkbox"/>
Undiagnosed lumps and bumps <input type="checkbox"/>	Sinusitis <input type="checkbox"/>	Inflamed nerve <input type="checkbox"/>
Localised swelling <input type="checkbox"/>	Neuralgia <input type="checkbox"/>	Hay fever <input type="checkbox"/>
Inflammation <input type="checkbox"/>	Migraine/headache <input type="checkbox"/>	Urticaria <input type="checkbox"/>

Skin test – (Select if/where appropriate):				
Moisture content:	Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>
Muscle tone:	Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>
Elasticity:	Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>
Sensitivity:	High <input type="checkbox"/>	Medium <input type="checkbox"/>	Low <input type="checkbox"/>	
Skins healing ability:	Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>
Skin tone:	Fair <input type="checkbox"/>	Medium <input type="checkbox"/>	Dark <input type="checkbox"/>	Olive <input type="checkbox"/>
Circulation:	Good <input type="checkbox"/>	Normal <input type="checkbox"/>	Poor <input type="checkbox"/>	
Pores:	Fine <input type="checkbox"/>	Dilated <input type="checkbox"/>	Comedones <input type="checkbox"/>	Milia <input type="checkbox"/>
Skin type:	Normal <input type="checkbox"/>	Dry <input type="checkbox"/>	Oily <input type="checkbox"/>	Combination <input type="checkbox"/>
Skin condition:	Young <input type="checkbox"/>	Mature <input type="checkbox"/>	Dehydrated <input type="checkbox"/>	Sensitive <input type="checkbox"/>
Overall skin type/analysis:				
Treatment to include (select where appropriate):	Colour photographic make-up <input type="checkbox"/>		Black and white photographic make-up <input type="checkbox"/>	
				

Treatment details – (to include products/colours used and make-up chart):	
Cleanser:	
Toner:	
Moisturiser:	
Pre-base:	
Concealer:	
Foundation:	
Shader:	
Highlighter:	
Powder:	
Cheek product:	
Eyebrow products:	
Eyeshadow:	
Eyeliner:	
Mascara:	
Lip liner:	
Lip products:	
Additional make-up products:	

Before and after photographs:

Client feedback:

Aftercare advice:

Therapist/learner signature: _____

Client signature: _____

Document History

Version	Issue Date	Changes	Role
v1	19/12/2019	First published	Qualifications Administrator