Treatment Evidence Form

iUBT428 – Make-up

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

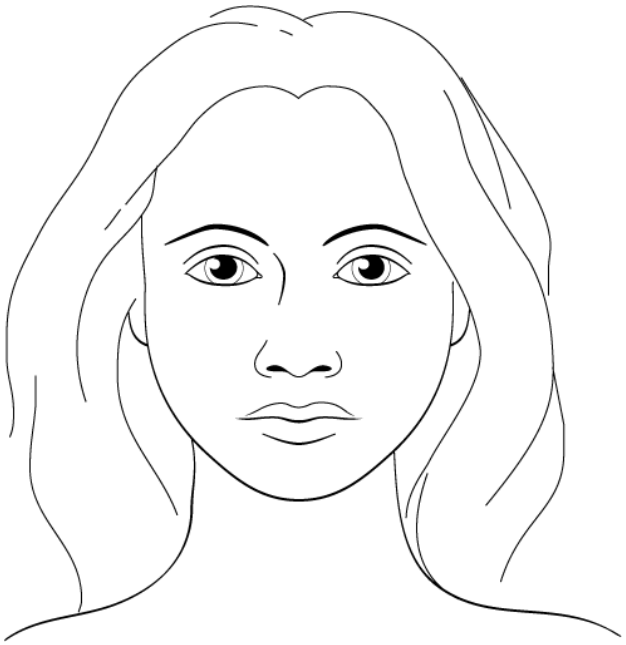
Client name:		
Address:		
Profession:		
Telephone number:	Day:	
	Evening:	

Personal details:						
Age group:	Under 20 ☐	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 ☐	Sunburn ☐	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):*	Day make-up ☐	Evening make-up ☐	Special occasion make-up ☐	Bridal make-up ☐
	Other ☐			
				

Treatment details – *(To include product/colours used, make-up chart and before and after photographs)*

Make-up Chart:	
Pre-base:	
Concealer:	
Corrective cream:	
Foundation:	
Powder:	
Blusher:	
Shader:	
Highlighter:	

Eye shadow:	
Eye liner:	
Mascara:	
Lip liner:	
Lipstick:	
Lip gloss:	

Client feedback:

Aftercare feedback:

Therapist/Learner signature: _____

Client signature: _____

Document History

Version	Issue Date	Changes	Role
v1	30/09/2019	First published	Qualifications and Regulation Co-ordinator
v2	08/01/2019	Republished	Qualifications and Regulation Co-ordinator
v3	14/01/2019	Amended consultation to treatment evidence	Qualifications and Regulation Co-ordinator