SOOTHE & SCULPT

Full Body Massage, Lymphatic Drainage & Body Sculpting

Brow Client Information Form

	Name	Date	
	Address	Email	
	Post Code	Contact Number	

Check if you have ever suffered from the following:

○	Eczema	○	Psoriasis	○	Stye
○	Sunburn	○	Conjunctivitis	○	Moles
○	Skin Cancer	○	Recent scar tissue	○	Allergies
○	Cold-sore	○	Diabetes	○	Blood/circulatory disorder
○	Uncontrolled epilepsy	○	Blood bone viruses	○	Hemophilia

***Contact lenses must be removed during the proced.*

***If you have inflamation, swelling, cuts, or abrasions in the treatment area, the procedure cannot be done.*

- Are you pregnant of breatfeeding? ○ Yes ○ No
- Are you taking medication that could affect then treatment (blood thinners, roacutane, etc.)? ○ Yes ○ No

Any additional information _____

***I understand that patch test does not guarantee that an allergic reaction will occur.*

Tint patch test area _____ Date _____ Result _____

I have completed this form to the best of my ability and knowledge and agree to inform the technician of any changes in the above information. I have been informed and understand the contradictions to the requested treatments and agree that I do not have any condition(s) that would make the requested treatmemt unsuitable.

_____ Client Signature

_____ Technician's Signature