Name

Address

Postcode

Email

Tel

Mobile

Date of Birth D D M M Y Y

Doctors Name

Address

Postcode

Have you had any recent operations or major illnesses in the past 6 months? If yes, please give details: Yes ☐ No ☐

Are you taking any regular medication? If yes, please give details: Yes ☐ No ☐

Contra-Indications -

Diabetes Yes ☐ No ☐

Skin disorders/diseases Yes ☐ No ☐

Any known allergies Yes ☐ No ☐

Epilepsy Yes ☐ No ☐

Pregnancy Yes ☐ No ☐

Under supervision of an oncologist within the past 12 months Yes ☐ No ☐

What skin care are you currently using?

For facial/massage treatments - what do you hope to achieve from your treatment?

Please specify any requests regarding your treatment today

Sign ---------- ***Date*** ----------