

Name

Address

 Postcode

Email

Tel

Mobile

Date of Birth

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 <input type="checkbox"/> No <input type="checkbox"/> | Epilepsy | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Skin disorders/diseases | Yes <input type="checkbox"/> No <input type="checkbox"/> | Pregnancy | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Any known allergies | Yes <input type="checkbox"/> No <input type="checkbox"/> | Under supervision of an oncologist within the past 12 months | Yes <input type="checkbox"/> No <input type="checkbox"/> |

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*