Brow Lamination

Name:	DOB:
Address:	Phone Number:

Do you suffer from any of the following?

	Yes	No
Diabetes	☐	☐
Infections skin disorder/disease	☐	☐
Undergoing chemotherapy	☐	☐
Recent PMU in area	☐	☐
Very sensitive skin	☐	☐
Severe/minor eczema or psoriasis	☐	☐
Anti-aging products	☐	☐
Moles/cysts/cuts/abrasions or swelling in the area	☐	☐

	Yes	No
Are you pregnant?	☐	☐
Positive reaction to the patch test	☐	☐
Recent brow lamination?	☐	☐
Allergic reaction to the patch test	☐	☐
Any known allergies	☐	☐
Acne treatment in last 6 months	☐	☐
Recent skin peels/microneedling dermaplaning/microdermabrasion or exfoliation	☐	☐

Details of above

Are you under medical supervision?

Are you taking any medication?

I declare that the information I have given is correct and as far as I am aware it is safe for me to undergo the treatment today with this establishment, with any adverse effects.

I have been fully informed about contra-indications and i will follow all aftercare given to me. I am willing to proceed with the treatment.

Date:	Patch test result:
Step 1 timing:	Tint choice:

Client signature:	Therapist signature:
Date:	Date: