SÉRONA
Beauty & Laser Clinic
www.seronabeautylongford.ie

CLIENT SKIN CONSULTATION AND CONSENT FORM

SERONA BEAUTY & LASER CLINIC

TREATMENT: ____________________ DATE: ____________

PERSONAL DETAILS

NAME: ____________________ DOB: ______ TELEPHONE: ______________

EMAIL ADDRESS: ____

ADDRESS: ____

DOCTOR'S NAME: ______________________ TELEPHONE: ______________

CONSULTATION QUESTIONNAIRE

HAVE YOU USED ANY ALPHA HYDROXY ACID (AHA) OR GLYCOLIC PRODUCTS IN THE PAST 48-72 HOURS? ______________________________

ARE YOU USING RETIN-A, RENOVA OR ACCUTANE (AN ORAL FORM OF RETIN-A)? ____

ARE YOU USING ANY SKIN THINNING PRODUCTS OR DRUGS? __________

ARE YOU PREGNANT OR NURSING?__________________________________

ARE YOU EXPOSED TO THE SUN OR SUNBED? ________________________

DO YOU SUFFER FROM EPILEPSY OR DIABETES? ______________________

ARE YOU CURRENTLY TAKING ANY MEDICATIONS?____________________

ARE THERE OTHER MEDICAL CONDITIONS OR ISSUES THAT YOUR THERAPIST SHOULD BE AWARE OF? ______________________________

HAVE YOU EVER BEEN TREATED FOR CANCER? IF YES, WHEN AND WHAT TYPES OF THERAPIES WERE USED?________________________________

DO YOU WEAR CONTACT LENSES?__________________________________

DO YOU HAVE ANY ALLERGIES?____________________________________

DO YOU HAVE ANY SKIN CONDITIONS SUCH AS PSORIASIS?___________

DO YOU HAVE ANY RECENT SCARS (UNDER 6 MONTHS OLD) OR SUFFER FROM KELOID SCARRING?____

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SKIN QUESTIONNAIRE

WHAT IS YOUR MAIN CONCERN WITH YOUR SKIN?

WHAT WOULD YOU LIKE TO ACHIEVE?

DO YOU EXERCISE AND HOW OFTEN?

HOW MUCH SLEEP DO YOU GET PER NIGHT?

AAFROM TODAYS CONSULTATION?

HAVE YOU EVER HAD CHEMICAL PEELS, LASER OR MICRODERMABRASION?

WHAT SKIN CARE PRODUCTS ARE YOU CURRENTLY USING? (LIST BRAND WHERE KNOWN)

WHAT AREAS OF CONCERN DO YOU HAVE REGARDING YOUR: SKIN: (PLEASE CHECK ANY THAT APPLY AND EXPLAIN)

- ☐ BREAKOUTS/ACNE
- ☐ BLACKHEADS/WHITEHEADS
- ☐ EXCESSIVE OIL/SHINE
- ☐ ROSACEA
- ☐ BROKEN CAPILLARIES
- ☐ REDNESS/RUDDINESS
- ☐ DEHYDRATED
- ☐ SUN SPOT
- ☐ UNEVEN SKIN TONE
- ☐ SUN DAMAGE
- ☐ WRINKLES/FINE LINES
- ☐ DULL/DRY SKIN
- ☐ FLAKY SKIN

____

HOW MUCH WATER DO YOU DRINK A DAY?

DO YOU HAVE A HEALTHY DIET?

DO YOU CONSUME A LOT OF SUGAR?

ARE YOU TAKING THE CONTRACEPTIVE PILL?

DO YOU SMOKE OR DRINK?

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CONSENT

I HAVE BEEN ADVISED THE SERVICE(S) PROVIDED TO ME BY THIS SALON COULD HAVE UNFAVORABLE RESULTS INCLUDING, BUT NOT LIMITED TO: ALLERGIC REACTION, IRRITATION, BURNING, REDNESS, SORENESS, ECT.

I AM AWARE THAT CERTAIN MEDICATIONS AND OVER THE COUNTER PRODUCTS CAN SIGNIFICANTLY INCREASE THE RISK OF INJURY WHEN COMBINED WITH SERVICES. I UNDERSTAND THAT SERONA BEAUTY AND LASER CLINIC DOES NO RECOMMEND SERVICES FOR CUSTOMERS USING RETIN-A, ACUTANE AND PRODUCTS CONTACTING ALPHA HYDROXYL, OR ANY OTHER SKIN THINNING TREATMENTS.

I HEREBY CONFIRM THAT I AM NOT USING ANY MEDICATIONS THAT MAY CAUSE OR CONTRIBUTE TO SUCH INJURY/REACTION, AND I WILL ADVISE MY THERAPIST SHOULD I USE ANY SUCH MEDICATIONS IN THE FUTURE.

I UNDERSTAND THERE ARE OFTEN RISKS ASSOCIATED WITH SERVICES, AND I AGREE THAT AS A CONDITION OF PROVIDING THESE SERVICES ON AN ON GOING BASIS, I WILL NOT HOLD SERONA BEAUTY AND LASER CLINIC AND THERAPIST LIABLE

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CLIENTS SIGNATURE *THERAPISTS SIGNATURE*

______________________________ ______________________________