SKIN FORMULAS

Client

QUESTIONAIRE

Full Name(s):

Date of Birth: | Are you Male or Female? M F

Address:

Mobile:

Email:

Are you currently seeing your doctor for any medical conditions or medication? Y N

Do you have any allergies (including Salicylic/aspirin, nut or latex)? Y N

Have you ever had a skin allergy/reaction after a treatment? Y N

Have you ever had chemotherapy/radiotherapy? Y N

Are you prone to cold-sores/lip herpes? Y N

Could you be pregnant, planning a pregnancy or breastfeeding? Y N

Are you planning a sun holiday in the next 6 weeks? Y N

Do you wear contact lenses? Y N

I hereby give my consent and authorisation voluntarily and release Geraldine Jones Ltd. from any claims, implied or stated that I have or may have in the future with this treatment, regardless of result. I am stating that the treatment and precautions above have been explained to me in detail and I fully understand.

Do not sign this form until you have read and understood the entire contents of this page and all your questions have been satisfactorily answered.

Signature:

Date: