The Lounge beauty & wellbeing Consultation Form

Please note this form must be kept for a minimum of 7 years for insurance purposes (all sections with a * need to be completed)

*Client name _____ *Date of birth _____/_____/_____

Address _____

Postcode _____*Contact number _____ Mobile _____

Email address _____

What communications would you like to receive from us?

Appointment Reminders ☐
Promotions and Offers ☐
Other ☐

How would you like to receive them?

Mobile SMS ☐
Email ☐

***Doctor's name and address:**

_____

* Health and Wellbeing			Additional Information
Under 18 years of age	Yes	No	
Heart conditions/pacemaker	Yes	No	
Severe circulatory disorders/DVT	Yes	No	
Diabetes	Yes	No	
Skin disorders e.g. Herpes, warts, acne	Yes	No	
Kidney problems	Yes	No	
Swelling/oedema	Yes	No	
Haemophilia	Yes	No	
Cancer	Yes	No	
Limitation of body movement/arthritis	Yes	No	
Prone to keloid scarring	Yes	No	
Hormone imbalance	Yes	No	
Stroke	Yes	No	
Claustrophobia	Yes	No	
Hepatitis	Yes	No	
Metal plates/pins/piercings	Yes	No	
Recent scar tissue/surgery	Yes	No	
Respiratory problems	Yes	No	
Any conditions affecting the ears/eyes	Yes	No	
Allergies of any kind	Yes	No	Please specify:
Latex allergy	Yes	No	
Are you pregnant/breast feeding	Yes	No	
Epilepsy	Yes	No	
High/low blood pressure	Yes	No	
Operations within 6 months	Yes	No	
HIV/AIDS	Yes	No	

***Any other medical conditions/ailments yes/no**

Please specify

_____

Are you taking Medication/Treatments			**Additional information**
Steroids	Yes	No	
Anti-Inflammatory medication	Yes	No	
Ultra violet exposure/Sunbathing	Yes	No	
Laser/IPL	Yes	No	
Retinol or Roaccutane	Yes	No	
Products containing fruit acids	Yes	No	
Microdermabrasion	Yes	No	
Injectables e.g. fillers Botox	Yes	No	
Any other medications?	Yes	No	Please specify:

*****Declaration I declare that the above information I have given concerning my health is correct

Signature_____ Date_____/_____/_____

*COVID-19 Health Assessment Questionnaire

For the foreseeable future a health assessment questionnaire must be completed and sent in, together with your new consultation card if this is your first ever appointment, or sent in on its own ahead of each appointment stored and documented by your therapist on each appointment update thereafter.

Date Completed	Signature

***Updates/Changes**

Please advise us of any personal or medical changes applicable to this consultation form since your last treatment with us? If none, state NONE with your signature and date.

Date	Amendment of details	Signature

Please NOTE remember to attach all relevant patch test forms and parental consent forms where applicable