Consultation Form

NAME:	NAME OF GP:
ADDRESS:	NAME OF SURGERY:
	SURGERY TEL:
HOME TEL:	D.O.B
MOBILE:	FACEBOOK? Y / N
E.MAIL:	

Do you suffer from/have you suffered from the following (please tick all that apply)

FUNGAL INFECTIONS		HEAT RASH		CLAUSTROPHOBIC	
BACTERIAL INFECTIONS		SUN BURN		HEART MUMAR	
VIRAL INFECTIONS		WARTS		PROLONGED BLEEDING	
PARASITIC INFESTIONS		HAIRY MOLES		HEART CONDITIONS	
ECZEMA		ABNORMAL HAIRGROWTH		PALPITATIONS	
PSORIASIS		SPLIT NAILS		ASTHMA	
BRUISING		BRITTLE NAILS		ALOPECIA	
SCAR TISSUE		HANG NAILS		HEALING PROBLEMS	
BITTEN NAILS		DRY CUTICLE		PREGNANT	
BROKEN BONES		NAIL SEPERATION		WEAR CONTACT LENSES	
CUTS		HAYFEVER		USE SUN BEDS	
ABRASIONS		LATEX GLOVES		LANOLIN	
SWELLING		VINYL GLOVES		VASELINE	
CONJUNCTIVITIS		ACETONE		NUTS	
WATERY EYES		PEROXIDE		MEDICATION	
SKIN ALLERGIES		FAINTING SPELLS		METALS	
BOILS		DIZZINESS		RUBBER	
DERMATITIS		EPILEPSY		CRAYONS	
DIABETES		CANCER		FOODS	
VARICOSE VEINS		STROKE		OTHER PLEASE LIST	
SKIN DISORDERS		HEPATITIS			
SKIN DISEASES		LASER PEEL			

Please list any medications that you have taken or are taking within the last 12 months:

Are you currently seeing your GP for any medical conditions?	YES	NO
Have you ever seen a dermatologist?	YES	NO
Have you had any operations in the last 12 months?	YES	NO

I accept that any treatment I have is taken at my own risk. I certify that I have read and have completed the above to the best of my knowledge. I understand that failure to disclose information requested above may result in adverse side effects, unknown because of this to which I accept full liability/responsibility.

I fully understand the above and consent/permit the treatment/s to be carried out. The undertaken of the treatment/s has been fully explained to me. I accept full responsibility for this and or other complications, which may arise or result during or following any procedure that is performed at my request.

Following the new GDPR regulations May 2018, I am happy to be compliant and give my details above for appointment reminders via text & email and I also give permission for emails to be sent to me for news, discounts and promotions.

I am happy for any photos taken, can be shared on social media platforms.

I accept that if I am not satisfied with the treatment I will inform the therapist and/or request to speak to the manager immediately following the treatment.

SIGNED:

PRINT NAME:	DATE:
THERAPIST NAME:	DATE:

TREATMENT	DATE
CLIENT PRINT NAME	THERAPIST
CLIENT SIGN	
COMMENTS	

TREATMENT	DATE
CLIENT PRINT NAME	THERAPIST
CLIENT SIGN	
COMMENTS	

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