

**Lash Lift and/or Tint Client Consult Form**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had a lash lift and/or tint before?\_\_\_\_\_\_\_\_\_ Reactions?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Circle any previous discomfort or reactions: skin disorders, eye infections, watery eyes,

Seasonal allergies, allergies to latex/band-aids, eye surgery, inflammation of the skin, hayfever, previous reactions to eye treatments, allergies, bell’s palsy, eye disease

Do you wear contacts?\_\_\_\_\_ Are you pregnant/nursing?\_\_\_\_\_ Contraceptive/HRT?\_\_\_\_\_

Any medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had lash extensions in the past?\_\_\_\_\_\_\_\_\_\_ If so, why did you stop?\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have requested and agreed to the following treatment today without having a patch test done previously. I patch test may indicate my sensitivity or allergy to the products. I take full responsibility and understand the contraindications and aftercare and release the technician, employer and all other parties of their responsibility associated with the supply of the products and services performed. I understand that there is no guarantee of the service, outcome, longevity of the lift and/or tint. All aftercare has been discussed with me prior to the start of the service.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Technician Signature

\_\_\_\_\_I give my permission to be photographed before and after the lash lift treatment and for my photos to be used for marketing/social media purposes or any other means without compensation.

\_\_\_\_\_I do NOT give my permission for my photos to be used for marketing/social media purposes but understand that my photo will still be necessary for portfolio/business purposes only.

***For technician use only:***

Date\_\_\_\_\_\_\_\_ Lash Health\_\_\_\_\_\_\_\_\_\_\_\_ Lash Length\_\_\_\_\_\_\_\_\_\_ Shield Size\_\_\_\_\_\_\_\_\_\_\_\_

Tint Color\_\_\_\_\_\_\_\_\_\_\_\_\_ Tint Time\_\_\_\_\_\_\_\_\_\_\_ Lash Lift Timing\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_ Lash Health\_\_\_\_\_\_\_\_\_\_\_\_ Lash Length\_\_\_\_\_\_\_\_\_\_ Shield Size\_\_\_\_\_\_\_\_\_\_\_\_

Tint Color\_\_\_\_\_\_\_\_\_\_\_\_\_ Tint Time\_\_\_\_\_\_\_\_\_\_\_ Lash Lift Timing\_\_\_\_\_\_\_\_