Client Evaluation Form for Lash Extensions

Name: _____

Address: _____City:_____State_____Zip:_____

Home/Cell Phone: _____ Email: _____

How should we contact you? Home/Cell Phone:_____Text:_____Email:_____
How did you hear of us? _____
Health History Please list any allergies you have (including cosmetics/ingredients):_____
_____

Are you allergic to Acrylate/Cyanoacrylate (bonding agent)? Yes / No / Don't Know

Have you ever had a reaction to adhesive tape, topical creams, nail adhesives, or other topical products? Yes/No

Do you have any eye disease, condition or injury that has affected your hair/lash growth or loss? Yes/No Please list all current medications you are taking (including over-the-counter herbs, vitamins and supplements):_____.·_____
_____

Have you ever had any of these conditions? (Please circle)

Alopecia	Asthma	Back Pain	Blepharitis	Cancer/chemo	Claustrophobia
Conjunctivitis	Diabetes	Dry Eye	Eating Disorder	Hormonal Imbalance	Intense Stress
Light Sensitivity	Migraines	Rosacea	Sensitive Eyes	Stroke/ TIA	Thyroid Disease
Recent Eye Surgery	Currant eye irritation	Possible Pregnancy	Watery eyes		

Any other health condition not listed: _____

These questions are relevant to your hair growth, and overall hair health. Please answer as fully as possible.

Question	*Y*	*N*	*Details*	*Adverse Reactions*
Are you pregnant or nursing?				
Do you wear contacts?				
Do you wear glasses				
Do you use Retin-A or Accutane?				
Do you go tanning?				
Have you had facial treatments?				
Have you had Botox or injections?				
Do you use Latisse or lash growth products?				

Which side do you most often sleep on? __Right __Left __Stomach __Back

How fast do you feel your hair grows? __Fast __Slow __Normal Rate

Is there anything else we should know about? _____

_____

Although every precaution will be taken to ensure your safety and wellbeing before, during and after your lash extension application, please be aware of the following information and possible risks. Please initial:

___ I understand that lash extension services have some inherent risk of irritation to the orbital eye area, including the eye itself, and could result in stinging and burning, blurry should the adhesive enter the eye or should an allergic reaction occur.

___ I understand that some irritation, itching or burning may occur on the skin if the bonding agent comes into contact with it.

___ I understand that if the bonding agent comes into contact with my eye, my eye will be flushed with water and I will be assisted in seeking medical attention immediately.

___ I understand that this is a semi-permanent procedure, as my natural lashes will continue to grow and fall out normally, making touch-up or "fill" appointments necessary to maintain the original look achieved by replacing the lashes that have fallen out. Most clients require a fill appointment every 2-3 weeks.

___ I understand that it is imperative that I disclose all of the information requested in the Client Profile/Health History.

___ I have cited all conditions and circumstances regarding my health history, medications being taken, and any past reactions to products or medications.

___ I understand that additional conditions could occur or be discovered during the procedure which could affect my ability to tolerate the procedure.

___ I consent to "before and after" pictures for the purpose of documentation, potential advertising and promotional purposes.

I understand that if I have any concerns, I will address these with my technician. I give permission to my technician to perform the lash extension procedure we have discussed, and will hold him/her and his/her staff harmless and nameless from any liability that may result from this treatment. I have accurately answered the questions above, including all known allergies, prescription drugs, or products I am currently ingesting or using topically. I understand my lash extension specialist will take every precaution to minimize or eliminate negative reactions as much as possible. In the event I may have additional questions or concerns regarding my treatment, I will consult the lash extension specialist immediately. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read, and fully understand, the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered. I understand the procedure and accept the risks. I do not hold the lash extension specialist, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this procedure, which may be affected by the treatment performed today.

Client Name (Printed)_____

Client Name (Signature)_____Date:_____

Lash extension specialist: Tahzae Letcher Tahzae Letcher Date: 2/22/2020

Date	Fee	Service	Curl	W.	L.	V.	Notes
3/5/10	$20	Full Fill					Removal
		Full Fill					
		Full Fill					
		Full Fill					
		Full Fill					
		Full Fill					
		Full Fill					
		Full Fill					
		Full Fill					
		Full Fill					