SPA WESTERN

Lash Service Client Information & Consent Form

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

E-mail: _____

How should we contact you? Phone _____ Text _____ E-mail _____

How did you hear about Spa Western? _____

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 Eyes Eating Disorder Hormonal Inbalance Intense Stress

Light Sensitivity Migraines Rosacea Sensitive Eyes Stroke/TIA Thyroid Disease

Recent Eye Surgery Current Eye Irritation Possible Pregnancy Watery Eyes

Any other health conditions not listed:

_____

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

Are you pregnant or nursing? ☐ Yes ☐ No

Do you wear contacts? ☐ Yes ☐ No

Do you wear glasses? ☐ Yes ☐ No

Do you go tanning? ☐ Yes ☐ No

Have you had facial treatments? ☐ Yes ☐ No

Have you had Botox or injections? ☐ Yes ☐ No

Do you use Latisse or lash growth products? ☐ Yes ☐ No

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 extensions 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 or blurry vision 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 is 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 the information requested in the Client Profile/Health History.

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_____ 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 them with my technician.

I give permission to my technician to perform the lash extension procedure we have discussed, and will hold them and their staff harmless and nameless from any liability that may result from this treatment. I have accurately answered the questions on this form, 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 my 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 Signature: _____ Date: _____

Service Provider Signature: _____ Date: _____