

Client Record

Required for every client before their first treatment. Keep your answers short and relevant.

YOUR DETAILS

Full name

Date of birth

Mobile number

Email address

HEALTH AND SUITABILITY

Please tick Yes or No. These questions are only about matters that may affect the safety or suitability of lash treatment.

Do you have a current or diagnosed eye, eyelid or skin disorder/disease that may affect the eye area?

☐

Yes

☐

No

Do you have another health condition or disease that may affect your skin, immune system, healing or natural lashes?

☐

Yes

☐

No

Are you pregnant or breastfeeding?

☐

Yes

☐

No

Do you have any relevant allergy or sensitivity, or have you reacted to lash adhesive, tape, gel pads or cosmetics before?

☐

Yes

☐

No

Are you currently having, or have you recently completed, chemotherapy or another cancer treatment that may affect your lashes or skin?

☐

Yes

☐

No

If you answered Yes, please give brief details

AGREEMENT

☐

I confirm that the information above is accurate and I will tell Alexia if anything changes.

☐

I understand Alexia may postpone or decline treatment if it is not suitable or safe.

☐

I consent to this relevant health information being used confidentially to assess suitability and keep my treatment record.

Typed name / signature

Date

Please do not send this form through Instagram. Return it using the secure method provided with your appointment, or bring it with you.

Patch Test Form

Complete before your first eyelash-extension treatment. Choose one option only.

IMPORTANT INFORMATION

A patch test may identify an obvious sensitivity, but a negative result cannot guarantee that a reaction will not happen during or after a full treatment. Sensitivity can also develop later.

Please discuss patch testing with Alexia before your first appointment. Your patch-test arrangements will be confirmed before treatment.

YOUR CHOICE

- ☐ I REQUEST A PATCH TEST. I will report any redness, itching, swelling, pain or other concern before treatment.
- ☐ I WISH TO DECLINE A PATCH TEST. I understand the limitations explained above. Alexia will review my choice and confirm whether treatment is suitable.

SAFETY

Tell Alexia about any reaction. Seek urgent medical help for breathing difficulty, marked swelling, severe pain, visual changes or rapidly worsening symptoms.

- ☐ I have read and understood this information, had the opportunity to ask questions and understand that treatment remains subject to consultation and suitability.

Full name

Date

Typed name / signature

Time

ALEXIA TO COMPLETE

- ☐ Patch test required / requested
- ☐ Decline permitted and recorded

Date, product, outcome and artist initials