EPILFREE®

CLIENT CONSULTATION FORM

Name & Surname: _____ DOB: _____

Address: _____

_____

Tel Home: _____ Tel Work: _____

Cellphone: _____ Email: _____

HAVE YOU EVER RECEIVED TREATMENT FOR THE FOLLOWING?

WAXING YES: ◯ NO: ◯

On what areas: _____ Any contraindications: _____

LASER / IPL YES: ◯ NO: ◯

On what areas: _____ Any contraindications: _____

VARICOSE VEIN TREATMENT YES: ◯ NO: ◯

On what areas: _____ Any contraindications: _____

BOTOX INJECTIONS YES: ◯ NO: ◯ If yes treatment must be postponed until **3-4 months** after last Botox injection

On what areas: _____ Any contraindications: _____

Note: Expect 30% less in results due to hair producing chemical IGI.

SHAVING YES: ◯ NO: ◯ How often: _____

On what areas: _____ Any contraindications: _____

HEALTH INFORMATION: Do you suffer from any of the following?

MEDICAL HISTORY:

Thyroid - Hypo ◯
Thyroid - Hyper ◯
Hirsutism ◯
PCOS (Polycystic Ovary Syndrome) ◯
Pre-menopause ◯
Pregnant ◯
Breastfeeding ◯
Infertility Treatment ◯
Axillary Hyperhidrosis ◯

Allergies ◯
Diabetes ◯
Cancer ◯
Lupus ◯
Eczema ◯
Rosacea ◯
Psoriasis ◯
Pigmentation ◯
Dermatitis ◯

Acne ◯
Anti Coagulants ◯
Cronic Medication ◯
Contraception ◯

SPECIFY ALL MEDICATION USED:

_____

_____

_____

VERY IMPORTANT CONTRAINDICATORS: PREGNANT OR BREAST FEEDING WOMEN CANNOT USE EPILFREE

GENERAL HEALTH INFORMATION

Rate your **STRESS LEVELS** with an 'x' 1 2 3 4 5 6 7 8 9 10

If your answer is between 5 & 10 specify what you think causes your stress:

Is there any other health information we should know about that has not been listed?

Rate your **ACTIVITY LEVELS** with an 'x' 1 2 3 4 5 6 7 8 9 10

If your answer is between 5 & 10 specify what activities you partake in during the day:

List what hobbies you do during the day:

DECLARATION:

I confirm that I have read, understand and answered the above questions correctly to the best of my knowledge. I hereby declare that all the information above is true.

I understand that I have to follow post treatment / aftercare to achieve optimum results.

I hereby give consent for photographs to be taken of the treated areas to assess progress.

Signature: Date:

DATE	AREA TREATED / COMMENTS	APPLICATION	THERAPIST