Facial Customer Consultation Form

Please fill out form, print and bring with you to your appointment.

Name

Telephone

Address

Cell Phone

Birthday

Fax Number

Referred by

Email

Please note: This form must be filled out and signed by the Customer wishing to begin a course of treatment. All treatments will be performed by fully trained operators using the recommended skin care products.

All the questions are answered truthfully by me and I understand that some conditions may be contraindications to receiving treatment. Patient will therefore not accept any liability for injury or damages as a result of false information given.

Please print name

Customer Name

Date

Therapist Name

On behalf of

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1. Do you have a serious illness? (Details)

2. Do you follow a regular exercise routine? (Yes/No)

3. Have you had any recent operations with general anesthetics? (Details)

4. Do you eat fast foods? (ex. KFC, McDonalds, etc.) (Yes/No)

5. Do you have a pacemaker? (Details)

6. Do you smoke? How many packs per day?

7. Are you under any physical or psychological treatment?

8. Have you ever had a tummy tuck or liposuction?

9. Do you have a hormone imbalance that you know of?

10. Do you have swollen feet?

11. Do you suffer from varicose veins? (Details)

12. Do you drink Coffee/Tea/Alcohol? How many cups or units?

13. Do you suffer from thyroid condition? (Details)

14. How many glasses of WATER do you drink per day?

15. Are you pregnant or trying to get pregnant?

16. Are you taking any medication? What are they?

Anagen
Hair, Face & Body Solutions

17. Are you epileptic or suffer from fits?

18. Do you include salads and fruits in your diet?

19. Do you have any metal implants? (Details)

20. Do you have a lot of carbohydrates, fats or meats?

21. Have you suffered from any skin conditions? (Details)

22. Do you include Iodine or Kelp into your diet?

23. Do you suffer from water retention? (Details)

24. Ever have an adverse reaction to electrical treatment?

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