

Client Intake Form

For Eyelash Extensions



General Information

Name

Date of Birth

Address

City

State

Zip Code

Phone #

Email

Occupation

Emergency Contact Name

Phone #

Would you like to be added to our email list for specials and discounts?

Yes No

How did you hear about us?

Eyelash Extension History

Is this the first time you have had lash extensions applied?

Yes No

If no, were they applied by a professional previously?

Yes No

Where were they applied previously?

Why did you remove them?

Do you use any of the following products on your eyelashes?

Mascara Yes No

Lash Serum Yes No

Do you do any of the following to your lashes?

Curl Yes No

Perm Yes No

Tint Yes No

Other: _____ Yes No

Do you wear glasses?

Yes No

Do you wear contact lenses?

Yes No

Do you have frequent eye irritation itching, or watery eyes?

Yes No

Are you or could you be pregnant?

Yes No

Do you have, or are you being treated for any kind of eye injury?

Yes No

If yes, please explain:

Are you allergic to any of the following?

Acrylic Yes No

Latex Yes No

Other: _____ Yes No

Are you currently taking any medications or supplements? Yes No

If yes, please explain:

Do you have any of the following conditions? (Please check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Alopecia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Cataract |
| <input type="checkbox"/> Conjunctivitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Dry Eyes |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Psoriasis Around the Eyes |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Recent Eye Infection | <input type="checkbox"/> Sensitive Eyes |

By signing below, I agree to the following:

I have completed this form to the best of my ability and knowledge. I agree to inform the technician of any changes in the above information. I agree that I do not have any condition(s) that would make the requested treatment unsuitable. I will inform the technician of any discomfort I may experience at any time during my treatment to allow them to adjust accordingly. I agree to waive all liability toward my technician and the salon for any injury or damages incurred due to any misrepresentation of my health.

Name Printed

Signature

Date