BEAUTY REFINERY

Belle Beauty Therapy Ltd
504 Dingwall Buidling, 87 Queen Street, Auckland 1010

All of the information you provide is confidential and will only be accessed by the therapists performing or assisting with your treatments. We ask for this information so that we can provide you with a safe and successful treatment.

PERSONAL PROFILE

Name
Date of birth
Phone
Email
Address

Occupation

Doctor/GP
Practice

ESSENTIAL MEDICAL INFORMATION

Allergies

Illnesses (for cancer see page 3)

Medications (include topical)

Injuries

HISTORY OF SENSITIVITY TO:

Any beauty therapy treatment:

Any skincare product:

Adhesive, sticking plaster, topical product:

ARE YOU PREGNANT?

Yes Weeks No

ARE YOU BREASTFEEDING?

Yes No

CONSENT

Upon reading and signing this consent form I understand that although all professional care is taken in delivering the best possible treatment and advice at the time, I will not hold Beauty Refinery clinic or staff liable, if for some unforeseen reason there is an adverse reaction or side effect during or after the treatment. I also agree to follow all home care advice given to me once I leave the premises.
I also understand that I am personally responsible for the after care of my skin once I leave the clinic. This consent applies to all treatments I have at Beauty Refinery, and I will update my information with my therapist should any of it change prior to treatment.
I confirm that I have read and understood Beauty Refinery's pre and post care treatment advice, and all of my questions have been answered.
I also confirm that I am 16 years of age or older.

Name: Date:

Signature:

DOES THIS APPLY TO YOU?	YES	NO
1. Any Autoimmune condition		
2. Diabetes		
3. Cancer (current or historical)		
4. Haemophilia		
5. HIV or Aids		
6. Any communicable disease of the blood		
7. High or low blood pressure (please circle which one)		
8. Any type of surgery in the last 12 months		
9. Any metal implants		
10. Epilepsy		
11. Any cuts/abrasions/blisters/verucas/warts/lesions		
12. Any undiagnosed lumps/lesions/irritations/illnesses		
13. History of or current herpes simplex (cold sore)		
14. Botox, fillers, or any injectables		
15. Sunburn		
16. Keloid scarring		
17. History of poor healing		
18. Hyperpigmentation - brown scar that forms when skin is injured eg insect bite, pimple, burn etc.		
19. Do you smoke?		
20. Have you ever been on Roaccutane, Isotane or any acne drug? If yes, when and for how long?		
21. Have you ever used any steroid cream on your skin eg Hydrocortisone? If yes when, where, and for how long?		
22. Have you ever had IPL or laser? If so what for, and where on your body?		
23. Please rate your current stress levels from 1 - 10 (10 being highest)		
24. Is there any other information you can think of that will be relevant to your treatment today or in the future?		

CANCER INFORMATION

We respectfully request this information so that we can make the necessary modifications to avoid causing you any discomfort during or after your treatment.

CANCER TYPE	TREATMENT TYPES	DATE FINISHED

SIDE EFFECTS/TREATMENT EFFECTS	AREA EFFECTED
Lymph nodes removed	
Lymphodema	
Implant	
Healing scar	
Loss of sensation	
Sensitivity	
Radiation burn	
Mild swelling	
Severe swelling	
Very dry or peeling skin	
Nail disorders	
Nausea	
Dizziness	
Pain	
Other: please give details	

CURRENT SKINCARE BRAND & PRODUCT NAME

Sunscreen

AHA, BHA or Exfoliator

Retinol, Retin A, or Retinoid

Cleanser and/or Toner

Moisturiser

Serum or Treatment

Eye Cream

Mask or Other

RECENT FACIAL TREATMENTS - WITHIN LAST 3 MONTHS

TYPE OF FACIAL WHEN SKINCARE BRAND CLINIC

DIET AND LIFESTYLE

Do you have a balanced diet?

Do you take any vitamins or supplements?

Do you take protein powder or bars?

Please list any types of exercise you take and how often:

How do you feel about your skin? What is your main concern?