Georgie's Beauty Box

CLIENT CONSULTATION FORM

CONTACT DETAILS

First Name: Surname:
Date Of Birth: Gender:
Address: County:

Postcode:
Telephone: Mobile:
Email:

MEDICAL HISTORY

Do you suffer from any of the following?

□	Allergies	□	Thyroid Problems	□	Headaches
□	High/Low Blood Pressure	□	Heart Condition	□	Varicose Veins
□	Eczema/Psoriasis	□	Cancer	□	IBS/Bowel Problems
□	Arthritis / Rheumatism	□	Epilepsy	□	Claustrophobia
□	Asthma / Lung Problems	□	Back Problems	□	Fungal Infection
□	Diabetes	□	Muscular Pain	□	Other

If you have ticked any of the above, please give details:

Are you currently on any medication or under medical supervision? □ Yes □ No
If yes, please give details:

Have you had any surgery or operations in the last 6 months? □ Yes □ No
If yes, please give details:

Are you pregnant or breast feeding? □ Yes □ No

I have read and understood the questions asked and confirm that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatments.

Signed: _____ Date: _____