

5 Elements Eyelash Intake Form

Name _____ Phone _____ Date ____/____/____

Address _____ City _____ State _____

DOB ____/____/____ Occupation _____ Email _____

How did you hear about us? _____

Would you like to receive emails regarding promotions, specials, and sales? **YES/NO**

Allergies: _____

Do you have asthma or any respiratory (breathing) problems? **Y / N**

Do you have any sensitivities (itchy eyes, seasonal hay fever, et.)? _____

Any medical problems (such as thyroid, alopecia, hair pulling, et.)? _____

Are you able to lie on your back comfortably for 2-3 hours? **Y / N** Are you pregnant? **Y / N**

Have you previously undergone an eyelash extension procedure? **Y / N**

If yes, what was the result and did you have any concerns or side effects? _____

Do you wear contact lenses? **Y / N** Would you be willing to remove them (it is recommended)? **Y / N**

What type of eye makeup remover do you use? _____

What type of mascara do you use? _____

Desired length/style of lash extensions: **Natural Longer Dramatic Cat Eye**

- Sleeping on my face, extreme weather changes, steam, sauna and other activities may damage the adhesive or crimp the extension and may require more frequent refills. I reviewed and understand the aftercare instructions and will do my part to help maintain my eyelash extensions.
- I understand that eyelash extensions require ongoing maintenance and that 'refill' fees are based on the time and/or the number of extensions that will need to be replaced at the 'refill' appointments. If I wait too long between 'refills', I may need to pay for a new full set. If I no longer wish to wear the eyelash extensions, my technician will remove them safely for a removal fee, and I will not try to remove them myself. If I do try and remove them myself, I accept all responsibility for any loss or damage of my eyelashes
- I will seek medical care (at my own expense) and contact my Lash Technician immediately if any allergic or adverse reaction occurs. All of my questions were answered and I understand the procedure and risks.
- I grant permission to use my before and after pictures for marketing or examples of my technician's work. (Before and after photos are a permanent part of the technician's records. You may opt out of marketing)
- I release 5 Elements Therapeutic Massage and my certified Lash Technician from any and all liability associated with this procedure. This procedure has many variables due to lifestyle, moisture, weather, extreme temperatures, natural eyelash shedding and other factors. The technician will assess and decide if I am a candidate for this service to the best of her ability. **No guarantees are made or implied.**
- I verify that I have read and understand the above statements and agree to them. Initial _____

By signing below, you attest that you have provided accurate and current information on this form and answered all medical and health related questions truthfully and completely. Your signature also certifies that you understand that 5 Elements Therapeutic Massage reserves the right to deny service to any client due to a health condition he or she has that may pose a potential risk to practitioners or other clients, including those that pose a risk of potential contamination to service areas. Furthermore, signing below verifies that you understand that you are responsible for informing 5 Elements Therapeutic Massage and/or its technicians of ANY and ALL changes to your health condition as regards any question on this form or any potential public health risk that may arise from any change in your health condition.

Print Name

Sign Name

Date