BOTANICA AESTHETICS

THIS DOCUMENT IS INTENDED TO COVER ALL TINTING AND LASHING SERVICES RECEIVED AT BOTANICA WELLNESS SANCTUARY INCLUDING LASH TINTING, BROW TINTING, AND EYELASH EXTENSION APPLICATION.

Thank you for taking the time to carefully fill out this form. The information you provide will help ensure that the esthetician has sufficient knowledge to perform a safe, effective service.

Name:_____
Address:_____
City:_____ State:_____
Zip:_____
Home/Cell Phone:_____
Mobile Carrier (if you would like to receive text messages) :_____
Email address:_____

Have you ever had your brows or lashes tinted? Yes/No

Have you ever used hair color before? Yes/No

Have you ever had an allergic reaction to hair color? Yes/No

What over-the-counter or prescription skin care products are you currently using?_____

Please list any illnesses or conditions you are being treated by a physician for:_____

Please list any medications you are taking, including over-the-counter herbs, vitamins and supplements:_____

List any allergies you have:_____

If you had an adverse reaction to a previous tinting, please explain:_____

Are you allergic to Acrylate/Cyanocarylate (bonding agent)? Yes/No/Don't Know

Have you ever had a reaction to adhesive tape, topical creams, nail adhesives, or other topical products? Yes/No

Do you have any eye disease, condition or injury that has affected your hair/lash growth or loss? Yes/No

These questions are relevant to your hair growth, and overall hair health. Please answer as fully as possible.

Question	Y	N	Details *If applicable*	Adverse Reactions? *If applicable*
Are you pregnant or nursing?				
Do you wear contacts?				
Do you wear glasses?				
Have you ever had lash extensions?				
Have you ever had lash extensions removed?				
Have you ever used long lasting or waterproof cosmetics?				
Do you use Retin-A or Accutane?				
Do you go tanning (in salon, outdoor, or spray tan)?				
Have you had facial treatments?				
Have you ever had Botox®, Juvederm®, or any other injectables?				
Have you ever used Latisse® or any other lash growing product?				

Have you ever had any of these conditions? (Please circle)

Alopecia	Asthma	Back pain/injury	Bell's Palsy	Blepharitis	Claustrophobia
Cold Sores	Conjuntivitis (pink eye)	Diabetes	Eye Sties/Sores	Leamy Eye	Lupus
Auto immune disease	Herpes of the eye	Light sensitivity	Migraines	Intense stress	Stroke/TIA
Dry Eye Syndrome	Current eye irritation	Recent eye surgery	Ocular Rosacea	Sensitive eyes	Thyroid Disease
Trichotillomania					

Although every precaution will be taken to ensure your safety and wellbeing before, during and after your service, please be aware of the following information and possible risks. Please initial:

_____ I understand that tinting lashes or brows and applying lash extensions has some inherent risk of irritation to the orbital eye area, including the eye itself, and could result in stinging or burning, blurry vision and potentially blindness should the tint or adhesive enter into the eye or should an allergic reaction occur.

_____ I understand that if the bonding agent, tinting agent, developer, or mixture of both accidentally comes into contact with my eye, my eye will be flushed with water and medical attention may be required.

_____ I understand that some irritation, itching or burning may occur to the skin if it comes in contact with the tinting or bonding agent.

_____ I understand that there may be some residual dark staining left on the skin following the tinting process of either my lashes, brows or both. This will fade and go away within a short time.

_____ I understand that, while every attempt will be made to provide me with my chosen color, everyone's hair absorbs color differently and my final results may not be the color I initially wanted.

_____ I understand that over the course of several weeks, the tint will gradually lighten and fade. Re-tinting will be required to keep the new color fresh. Most clients need to re-tint every 3-4 weeks.

___ I understand that eyelash extension application is a semi-permanent procedure, as my natural lashes will continue to grow and fall out normally, making touch-up or "fill" appointments necessary to maintain the original look achieved by replacing the lashes that have fallen out. Most clients require a fill appointment every 2-3 weeks.

___ I understand that while every attempt will be made to provide me with the length and fullness I have chosen, my final result may not be what I initially envisioned.

___ I understand that it is imperative that I disclose all of the information requested in the Client Profile/Health History.

___ I have cited all conditions and circumstances regarding my health history, medications being taken, and any past reactions to products or medications.

___ I understand that additional conditions could occur or be discovered during the procedure which could affect my ability to tolerate the procedure.

___ I consent to "before and after" photographs for the purpose of documentation, potential advertising and promotional purposes.

I have read the above information. If I have any concerns, I will address these with my esthetician. I give permission to my esthetician to perform the procedure we have discussed, and will hold him/her and his/her staff harmless from any liability that may result from this treatment. I have accurately answered the questions above, including all known allergies, prescription drugs, or products I am currently ingesting or using topically. I understand my esthetician will take every precaution to minimize or eliminate negative reactions as much as possible. In the event I may have additional questions or concerns regarding my treatment, I will consult the esthetician immediately. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read, and fully understand, the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered. I understand the procedure and accept the risks. I do not hold the esthetician responsible for any of my conditions that were present, but not disclosed at the time of this skin care procedure, which may be affected by the treatment performed today.

Client Name (Printed)_____

Client Name (Signature)_____

Date:_____