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D'OR BEAUTY & AESTHETICS CLINIC

Intake Form

Client Information

DATE : _____ DATE OF BIRTH : _____ AGE: _____

NAME : _____

GENDER : ☐ MALE ☐ FEMALE ☐ OTHER

CITY : _____ ZIP: _____ STATE: _____

PHONE : _____ EMAIL: _____

PHONE #: _____ ADDRESS: _____

EMERGENCY CONTACT : _____

HOW DID YOU HEAR ABOUT US ? _____

Would you like to be added to our email list for specials and discounts? ☐ YES ☐ NO

Medical History;

please tick any of the following condition you may currently have :

- Back / Neck pain
- Diabetes
- Cancer
- Infections
- Liver condition
- Skin diseases
- Sunburn
- Eczema
- Dermatitis
- Sensitive skin
- Cardiovascular disease
- Asthma
- Arthritis
- Fever
- Inflammation
- Abrasions
- Phlebitis, blood clots
- Active acne

IMPORTANT NOTE:

List any medications you take regularly, including vitamins, herbal supplements, asprin:

Any other conditions: _____

Any known allergies? _____

Are you having regular exercise? ☐ Yes ☐ N o

If yes how often and what type of exercise? _____

_____

Have you had any surgeries in the past year ? ☐ Yes ☐ N o

if yes, please explain : _____

_____

Have you had any medical problems? ☐ Yes ☐ N o

if yes, please explain : _____

Do you suffer from any auto-immune disease? _____

Previous cosmetic treatment in the past year ? _____

Do you have Neurological disorders? ☐ YES ☐ NO

Are you pregnant? ☐ YES ☐ NO

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.

DATE: _____ Signature: _____

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Cancellation Policy

Our main priority is to provide timely and high-quality care to our clients. To achieve this goal, we have implemented an appointment and cancellation policy to ensure that we can offer our services efficiently.
Due to the high demand for appointments, early cancellations enable us to offer timely care to other clients. When booking your appointment, we require a deposit, which will be credited towards your treatment costs.

We reserve specific time slots for your appointments to ensure that we can provide you with the best possible care. If you need to cancel or reschedule your appointment, we kindly ask that you inform us at least 24 hours before your appointment. This allows us to schedule another client for the same time slot. If you cancel with less than 24-hour notice, you will be charged a cancellation fee. In case you arrive more than 15 minutes late for your appointment, we will consider it a no-show, and you will be charged the cancellation fee.

Please feel free to contact us if you have any questions or concerns regarding our appointment and cancellation policy. By booking an appointment with us, you agree to our cancellation policy's terms and conditions and to pay the cancellation fee in case of a missed appointment.

Please print your name, sign, and date below to acknowledge your understanding and agreement to our appointment and cancellation policy.

CLIENT NAME (Printed):_____

CLIENT (Signature):_____

DATE: _____

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Release Form

I, _____ hereby grant and authorize_____ the right to take edit, alter, copy, exhibit, publish, distribute and make use of any and all pictures, videos and/or audio taken of me to be used in and/or for any lawful promotional materials including,but not limited to, newsletters, flyers, posters, brochures, advertisements, press kits, websites,social media sites and other print and digital communications, without payment or any other consideration.

This authorization shall continue indefinitely and extends to all languages, media, formats and markets now known or later discovered.

I waive any rights to royalties or other compensation arising or related to the use of the photograph or recording.

I understand and agree that these materials shall become the property of _____and will not be returned.

I hereby hold homeless and release_____ from all liability,petitions. and causes of action which I, my heirs, representatives, executors, administrators,or any other persons may make while acting on my behalf of my estate.

By signing below, I here by acknowledge that i have completely read and fully understand the above release agreement .

CLIENT NAME (Printed):_____

CLIENT (Signature):_____

DATE:_____

www.dorbeauty.co.uk louise@dorbeauty.co.uk 07776 115759

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Informed Consent

I, [insert client's full name], hereby consent to receive consultation services from [insert consultant's name and/or organization].

I understand that the purpose of the consultation is to provide me with professional advice, guidance, and recommendations related to [insert the specific topic or issue to be discussed]. The consultant will provide information and suggestions based on their professional expertise and experience, but it is ultimately my responsibility to make decisions and take action based on the information provided.

I acknowledge that the consultation may involve the disclosure of personal information, including sensitive or confidential information related to my personal and/or professional life. I understand that the consultant will maintain the confidentiality of any information disclosed during the consultation, subject to any legal or ethical obligations to report certain information.

I understand that there are risks associated with receiving consultation services, including the possibility that the advice or recommendations provided may not be effective or appropriate for my particular situation. I acknowledge that the consultant is not responsible for any consequences that may result from my decisions or actions based on the consultation.

I have had the opportunity to ask questions about the consultation process and any risks or benefits associated with it. I have also had the opportunity to review and discuss any fees or charges associated with the consultation services.

By signing below, I acknowledge that I have read and understand the terms of this consent form, and I agree to participate in the consultation services provided by [insert consultant's name and/or organization].

CLIENT NAME (Printed):_____

CLIENT(Signature):_____

DATE:_____-

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Client Consultation Record

DATE	TREATMENT	PRODUCTS	NOTES	PRICE

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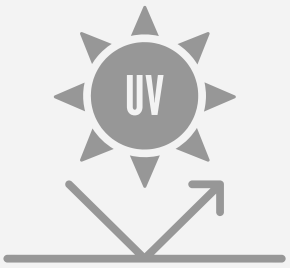
Aftercare Advice

Avoid exercise for 24–48 hours

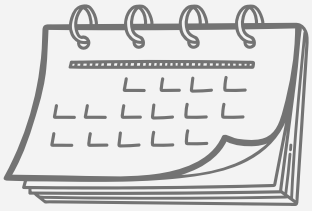


Avoid direct UV exposure

Use a soothing, antiseptic cream such as Bepanthen to treat the area

Do not consume alcohol in the first 24 hours to avoid thinning the blood

Do not use AHAs, BHAs, Retinol, or Vitamin C for 24 hours after the procedure



Maintenance schedule appointments every 6 to 8 weeks

PLEASURE DOING BUSINESS WITH YOU!

www.dorbeauty.co.uk louise@dorbeauty.co.uk 07776 115759