LASH EXTENSION
CLIENT INTAKE FORM

APPOINTMENT DATE: _____ APPOINTMENT TIME: _____

NAME:	AGE:	GENDER:
ADDRESS:	ZIP:	STATE:
EMAIL:	PHONE:	

Opt-in for email list to receive information & offers: ☐ Yes ☐ No

How you heard about us? ☐ Friends/Family ☐ Social Media Other: _____

Is this the first time that you have had eyelash extensions applied? ☐ Yes ☐ No

Please indicate if you have worn any of the following types of lashes within last 60 days:

☐ Strip ☐ Flare ☐ Individual ☐ Other: _____

Do you do any of the following to your eyelashes? ☐ Curl ☐ Perm ☐ Tint

Are you having eyelash extensions applied for: ☐ Daily wear ☐ A special occasion

Are you able to keep your eyes closed and lie still for up 2 hours or longer? ☐ Yes ☐ No

Which side do you most often sleep on? ☐ Left ☐ Right ☐ Stomach ☐ Back

How fast do you feel your hair grows? ☐ Fast ☐ Slow ☐ Normal

MEDICAL INFORMATION:

Please list any allergies you have: _____
(including cosmetics or Ingredients)

Are you allergic to bonding agent? ☐ Yes ☐ No ☐ I don't know
(Acrylate or Cyanoacrylate)

Have you ever had a reaction to adhesive tape, nail adhesives? ☐ Yes ☐ No

Do you have any eye disease, injury that affected your lash growth or loss? ☐ Yes ☐ No

If YES, Please describe it: _____

List all medications you are taking: _____
(including OTC drugs, vitamins etc.)

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

☐ Asthma	☐ Eating Disorder	☐ Stroke/ TIA	☐ Dry Eye	☐ Light Sensitivity	☐ Thyroid Disease	☐ Eye Irritation
☐ Alopecia	☐ Cancer/Chemo	☐ Diabetes	☐ Migraines	☐ Sensitive Eyes	☐ Eye surgery	☐ Pregnancy
☐ Back Pain	☐ Claustrophobia	☐ Blepharitis	☐ Rosacea	☐ Conjunctivitis	☐ Intense Stress	☐ Watery eyes

Any other health condition not listed: _____

This form is completely confidential. Completing this form gives the general state of health and assists our specialist in directing to provide customized treatment to you. The Information I have provided about my medical history on this form is genuine to the best of my knowledge, I have agreed to accept responsibility for omission regarding my failure to disclose any existing or past health condition.

Client Name	Client Signature	Date
Esthetician Name	Esthetician Signature	Date

LASH EXTENSION
CLIENT INTAKE FORM

APPOINTMENT DATE: _____ APPOINTMENT TIME: _____

NAME:	AGE:	GENDER:
ADDRESS:	ZIP:	STATE:
EMAIL:	PHONE:	

Opt-in for email list to receive information & offers: ☐ Yes ☐ No

How you heard about us? ☐ Friends/Family ☐ Social Media Other: _____

GENERAL INFORMATION:

Which side do you most often sleep on? ☐ Left ☐ Right ☐ Stomach ☐ Back

How fast do you feel your hair grows? ☐ Normal ☐ Fast ☐ Slow

Are you able to keep your eyes closed & lie still for up to 2 hours or longer? ☐ Yes ☐ No

Are you having eyelash extensions applied for: ☐ A Special Occasion ☐ Daily Wear

CLIENT LASH HEALTH:

Is this the first time that you have had eyelash extensions applied? ☐ Yes ☐ No

Do you wear contact lenses? ☐ Yes ☐ No

Do you get watery eyes from allergies or have sensitive eyes? ☐ Yes ☐ No

Have you had any eye issues in the last 4 weeks? ☐ Yes ☐ No

Do you perm or tint your eyelashes? ☐ Yes ☐ No

Do you habitually rub, pull, or pick your lashes for any reason? ☐ Yes ☐ No

Do you use any eye products (e.g. eye drops, lash serum, etc.)? ☐ Yes ☐ No

Have you ever had a reaction to adhesive tape or other topical products? ☐ Yes ☐ No

Do you have any eye disease, injury that affected your lash growth or loss? ☐ Yes ☐ No

Is this the first time that you have had eyelash extensions applied? ☐ Yes ☐ No

If no, where did you have them applied? _____

Please indicate if you have worn any of the following types of lashes within last 60 days:

☐ Strip ☐ Flare ☐ Individual ☐ Other: _____

What type of makeup remover and mascara do you currently use?

_____

What about your eyelashes would you like to enhance?

_____

Please list any eye drops or eye medication you are using:

_____

CLIENT HEALTH HISTORY:

Please list any allergies you have: _____
[Including cosmetics or Ingredients]

List all medications you are taking currently: _____
[including OTC drugs, vitamins etc.]

Are you allergic to bonding agent? ☐ Yes ☐ No
[Acrylate or Cyanoacrylate]

Do you have, or are you being treated for any eye illness or injury? ☐ Yes ☐ No

Do you have any eye disease, injury that affected your lash growth or loss? ☐ Yes ☐ No

If yes, please explain: _____

Do you have any of the following conditions? (please check)

HEAD NECK:
- ☐ Headaches or migraines
- ☐ Vertigo or dizziness
- ☐ Ringing in ears
- ☐ Hearing loss
- ☐ Vision issues or loss

SKIN & INFECTIONS:
- ☐ Hepatitis
- ☐ HIV / AIDS
- ☐ Herpes
- ☐ Lyme disease
- ☐ Infectious skin conditions

ANY OTHER:

RESPIRATORY:
- ☐ Asthma
- ☐ Shortness of breath
- ☐ Chronic cough
- ☐ Bronchitis
- ☐ Emphysema

CARDIOVASCULAR:
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Heart attack
- ☐ Stroke
- ☐ Heart disease

MUSCULOSKELETAL SYSTEM:
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Tendonitis
- ☐ Bursitis
- ☐ Jaw pain (TMJ)

EYE:
- ☐ Eye Infections
- ☐ Refractive Errors
- ☐ Dry Eye
- ☐ Diabetic Retinopathy
- ☐ Glaucoma

NERVOUS SYSTEM:
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Tendonitis
- ☐ Bursitis
- ☐ Jaw pain (TMJ)

OTHER CONDITIONS:
- ☐ Cancer
- ☐ Diabetes
- ☐ Chronic fatigue
- ☐ Unexplained Weight loss
- ☐ Fibromyalgia

Please check all that apply to you:

- ☐ Lasik Eye Surgery
- ☐ Permanent eye make-up
- ☐ Blephroplasty (eye lift)
- ☐ Microdermabrasion
- ☐ Child Birth within last 120 days
- ☐ Alopecia
- ☐ Thyroid diseases
- ☐ Allergic to Glycerin
- ☐ Recent severe illness
- ☐ Recent high fever
- ☐ Iron Deficiency
- ☐ Hormonal imbalance
- ☐ Extreme stress
- ☐ Bumps On Arms
- ☐ Eating Disorders
- ☐ Drugs that can cause temporary hair loss
- ☐ Chemotherapeutic agents to cure cancers.
- ☐ Retinoids (such as Accutane or Retin A)
- ☐ Anticoagulants
- ☐ Beta-adrenergic blockers for blood pressure
- ☐ Oral contraceptives
- ☐ Major surgery within last 120 days

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Client Name [Printed]	Client Signature	Date
Lash Technician Name	Lash Technician Signature	Date

LASH EXTENSION
CLIENT CONSENT FORM

Although every precaution will be taken to ensure your safety and wellbeing before, during & after your lash extension application, please be aware of the following information & possible risks.

Please Initial:

____I understand that it is my responsibility to keep my eyes closed and be still during the entire procedure until my eyelash technician addresses me to open my eyes.

____I understand that lash extension services have some inherent risk of irritation to the orbital eye area, including the eye itself, and could result in stinging and burning, blurry vision and potential blindness should the adhesive enter the eye or should an allergic reaction occur.

____I understand that some irritation, itching, or burning may occur on the skin if bonding agent comes into contact with it.

____I understand that if the bonding agent comes into contact with my eye, my eye will be flushed with water and I will be assisted in seeking medical attention immediately.

____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's Medical 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 an eyelash fill would be recommended every 2 to 3 weeks.
We will not be held liable for any damage that you may cause by trying to remove the eyelash extensions on your own.

____I have read and completed the Eyelash Extensions Intake & Consent form in its entirety, and have answered everything to the best of my ability. I have been informed of potentially harmful or negative side effects that may be caused by the application and/or removal of Eyelash Extensions.

I understand that if I have any concerns, I will address these with my lash extension specialist. I permit my lash extension specialist to perform the lash extension procedure we have discussed and hold him/her and his/her staff harmless and nameless from any liability resulting 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 lash extension specialist 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 lash extension specialist 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 lash extension specialist, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this procedure, which may be affected by the treatment performed today.

By signing below, I verify that I have read and understand the above statements and agree to them.

Client Name	Client Signature	Date
Esthetician Name	Esthetician Signature	Date