PRE TREATMENT FORM

SHIMMER BEAUTY AND SHAPERS SALON

Name _____ Marital Status _____ Date of Birth _____

Mobile No. _____ Email Address _____

☐ Tick here if you DO NOT wish to receive emails regarding what's new, special offers and latest beauty news.

The following information is needed to ensure your comfort and well-being as a guest of Shimmer Salon. Additional information about the relevance of these questions is available upon request. We may ask you to update your record from time to time. We have taken measures to ensure the security and confidentiality of the information contained on this document.

1. Are you feeling well today? ☐ Yes ☐ No

2. Are you currently under the care of a health care provider? (Including an obstetrician or fertility specialist)

☐ Yes ☐ No

3. Have you had any change in your well-being since your last visit? ☐ Yes ☐ No

4. Are you currently taking prescription medication (such as Retin A, Accutane, Insulin, or other) or supplements that could potentially affect any of your services today? ☐ Yes ☐ No

5. Do you have any areas of concern today? ☐ Yes ☐ No

6. Do you have any health concerns (such as allergies, high blood pressure, diabetes, etc.) that could be affected by your services today? ☐ Yes ☐ No

Additional Information:

_____

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I confirm that, to the best of my knowledge, the answers above are correct, and I have not withheld any relevant information. I hereby agree to assume all risk and responsibility and to hold the Salon and its employees harmless in the event I sustain any injury or damage to my person, directly or indirectly, as a result of my receiving services, and I further agree to release the Salon and its employees from any claim, cause of action, suit, damages, etc. that may result from any such injury or damage.

Print Name _____ Signature _____ Date _____

Therapist Comment:

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