

Client Evaluation Form for Lash Extensions

Name: _____

Address: _____ City: _____ State _____ Zip: _____

Home/Cell Phone: _____ Email: _____

How should we contact you? Home/Cell Phone: _____ Text: _____ Email: _____

How did you hear of us? _____

Health History Please list any allergies you have (including cosmetics/ingredients): _____

Are you allergic to Acrylate/Cyanoacrylate (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 Please list all current medications you are taking (including over-the-counter herbs, vitamins and supplements): _____

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

Alopecia	Asthma	Back Pain	Blepharitis	Cancer/chemo	Claustrophobia
Conjunctivitis	Diabetes	Dry Eye	Eating Disorder	Hormonal Imbalance	Intense Stress
Light Sensitivity	Migraines	Rosacea	Sensitive Eyes	Stroke/ TIA	Thyroid Disease
Recent Eye Surgery	Currant eye irritation	Possible Pregnancy	Watery eyes		

Any other health condition not listed: _____

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

Question	Y	N	Details	Adverse Reactions
Are you pregnant or nursing?				
Do you wear contacts?				
Do you wear glasses				
Do you use Retin-A or Accutane?				
Do you go tanning?				
Have you had facial treatments?				
Have you had Botox or injections?				
Do you use Latisse or lash growth products?				

Which side do you most often sleep on? __Right __Left __Stomach __Back

How fast do you feel your hair grows? __Fast __Slow __Normal Rate

Is there anything else we should know about? _____

