



ROK Beauty Bar
14 Hinrichsen Drive, Hallam, Vic

Ph: 0416 123 694

ABN: 69735972016

Wax, Lash, Tan, Gorgeous

CLIENT INFORMATION SHEET

FULL NAME: _____

DOB: _____

ADDRESS: _____

MOBILE PH: _____

EMAIL: _____

PROCEDURE: (please tick)

Waxing		Lash Lifting	
Spray Tanning		Tinting/Dye/Henna	
SPM (Semi-Permanent Mascara)		Brow Lamination	

SAFETY INFORMATION: (please tick)

Psoriasis/Eczema/Dermatitis		Aspirin or blood thinning medications	
Recent scarring (less than 6 months old)		Transmittable blood disease	
Previous eye surgery		Contact Lenses	
Eye irritation		Pregnant or breastfeeding	
Seasonal allergies		Chemotherapy (last 12 months)	
Eye infection or infection in eye area		Trichotillomania (hair pulling disorder)	
Recent cosmetic tattoo (last 6 weeks)		Blepharitis (inflammation of eyelids)	
Recent cosmetic injections (last 4 weeks)		Using topical steroid cream	
Recent sunburn		Very oily or dry skin	
Varicose veins		Allergy to adhesives/tapes/band-aids	
Bruising		Recent illness or operation	
Cuts/abrasions/open wounds		Using Vitamin A cream or Retinol	
Rash		Acne treatments eg. Roaccutane	
Thin/fragile skin		Diabetic	
Previous reaction to wax, tint, tanning solution		Allergy to latex, vinyl or acrylic	
Previous reaction to Henna products		Other	



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Have you had a waxing service before?	YES	NO
Have you had a spray tan before?	YES	NO
Have you had a lash lift before?	YES	NO
Have you had brow lamination before?	YES	NO
Have you had lash or brow tinting before?	YES	NO
Have you had Henna on your brows before?	YES	NO
Have you had semi-permanent mascara (SPM) before?	YES	NO

Would you like a patch test to be performed prior to any of your treatments? YES NO
If so, this should be performed at least 24-48 hours prior to your treatment. This may incur an additional cost. Please advise your therapist if you wish to have a patch test.

ROK Beauty Bar will not be held responsible for any injury or harm resulting from inadequate aftercare following procedures, or from the client withholding information that may affect their treatment.

Beauty Therapists are not able to give medical advice, therefore you should contact your Doctor if you experience any side effects or reactions from your treatment/s.

ROK Beauty Bar will send you confirmation messages regarding your appointments, and occasionally promotional material or special offers, via SMS and email. Please advise if you do not wish for this to occur.

All services must be paid for in full on the day of your treatment. ROK beauty Bar accepts cash, EFTPOS or credit card. A receipt will be issued to you after payment is received.

CLIENT CONSENT:

I understand I have the right to a patch test 24 hours prior to my procedure/s. If I waive the right to a patch test, I will be fully responsible for any consequence of any allergy or negative reaction that may result from the procedure/s.

I understand that vinyl gloves may be used during my procedure/s, and I consent to their use.

I understand that I must remove contact lenses prior to any lash treatment (lash tint, lash lift and SPM) being performed. Contact lenses can be re-inserted 8 hours after the treatment if no irritation or side effects have occurred.

I understand that I will need to inform my therapist of any medical changes that have occurred prior to my next appointment.



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I grant permission for ROK Beauty Bar to use my photograph, video or other digital media in any publications, including web based publications and social media, without payment or other consideration. YES NO

I understand this information and have given full disclosure regarding any contraindications that may affect my treatment to my therapist to the best of my knowledge. I understand that it is my responsibility to follow all aftercare advice as outlined below.

I understand that there are risks involved with beauty therapy procedures and I willingly give my consent for ROK Beauty Bar to perform these procedures on my person. I understand that the nature and process of the procedure/s I am having has been fully explained to me. I understand there are risks inherent in the procedure and there is a possibility of complications during and after the procedure.

I hereby acknowledge that all information I have provided to my therapist is true and correct, and I am fully aware of the risks of the procedure/s I am undertaking. I therefore take full responsibility for all possible outcomes of the procedure.

CLIENT SIGNATURE: _____ DATE: _____

If the client is under 16 years of age, parent/guardian permission is required, and must be present to witness all procedures being performed.

PARENT/GUARDIAN NAME: _____

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____