TINTING AND PERMING CLIENT ASSESSMENT & CONSENT FORM

Name:_____ **Date:**_____
Address:_____ **Phone:**_____
Email:_____ **Tinting Technician:**_____

Service to Receive: Tinting Eyebrows/ Tinting Eyelashes/ Perming Eyelashes (circle all that apply)

Although every precaution will be made to ensure your safety and well-being before, during and after your tinting application, please be aware of the possible risks below. Please Initial:

___I understand that the treatment is a safe procedure and there is no recovery time for most people.
___I understand that tinting eyelashes or eyebrows and perming eyelashes has some inherent risk of irritation to the orbital eye area, including the eye itself, and could result in stinging or burning, blurry vision and potentially blindness should the tint enter into the eye.
___I understand that if the tinting agent, developer, or mixture of both accidentally comes into contact with my eyes, my eyes will be flushed with water and saline solution and medical attention may be required.
___I understand that some irritation, itching or burning may occur to the skin which comes in contact with the tinting agent.
___I understand that there may be some residual dark staining left on the skin following the tinting process of either my lashes, brows, or both. This will fade and go away within a short time.
___I understand that, while every attempt will be made to provide me with my chosen colour, everyone's hair absorbs color differently and my final results may not be the colour I initially wanted.
___I understand that over the course of several weeks, the tint will gradually lighten and fade. Re-tinting will be required to keep the new colour fresh. Most clients need re-tinting every 3-4 weeks.

How did you hear about us? _____
Have you ever has your lashes and/or brows tinted?_____ **If yes, when?**_____
Have you ever had an adverse reaction to hair colour or previous tinting products?Please Explain:
_____

Do you wear contacts?_____
(treatment will be postponed if any sys surgery has been performed in the last 6 months)
Do you have any eye condition or injury?_____
Please list any medication you are using?_____
Are you allergic to latex or rubber?_____
Do you have any intolerance/allergy to:Chemicals, fragrances, odors, hair dyes, colour infrequence? If yes, specify:_____

Please Circle all that might apply to you:

Stress	Seasonal Allergies	Lumps/Cysts
Lasik Eye Surgery	Alopecia	Cold sores around eye
Permanent eye makeup	Hormonal Imbalance	Psoriasis
Diabeetes	Hypersensitive eyes	Pink eye
Blephatoplasty	Thyroid Diseases	Sty of the eye