Client Consultation Form

Electrical Epilation

2022 version 1.0

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| **Student name** | Click or tap here to enter text. | **ID #** | Enter text. |

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| **Client Information** | | | | | |
| **Client name** | Click or tap here to enter text. | | | **Cell #** | Enter text. |
| **Client address** | Click or tap here to enter text. | | | | |
| **Profession** | Click or tap here to enter text. | | | | |
| **Treatment date** | Enter date. | **Home #** | Enter text. | **Work #** | Enter text. |

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| **Personal details** | | | | | | | | | |
| **Age group** | Choose age group. | | **Lifestyle** | | Active |  | Sedentary | |  |
| **Last GP visit** | Click or tap to enter a date. | | | | | | | | |
| **GP name** | Click or tap here to enter text. | | | | | | | | |
| **GP address** | Click or tap here to enter text. | | | | | | | | |
| **No of children** | Choose an item. | *If applicable* | | **Last period** | Enter text. | | | *If applicable* | |

# Contraindications

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| **Contraindications requiring medical permission** – *where medical permission cannot be obtained, clients must give their informed consent in prior to treatment. Select if / when appropriate:* | | | | | |
| Pregnancy |  | Medical oedema |  | Diabetes |  |
| Cardiovascular conditions[[1]](#footnote-1) |  | Nervous / psychotic conditions |  | Asthma |  |
| Haemophilia |  | Epilepsy |  | Any dysfunction of the nervous system[[2]](#footnote-2) |  |
| Any condition being treated by a GP or another practitioner |  | Recent operations |  | Neuralgia |  |
| Inflamed nerve |  | Cancer |  | Spastic conditions |  |
| Whiplash and any neck conditions |  | Slipped disc |  | Undiagnosed pain |  |
| When taking prescribed medication |  | Endocrine disorders |  |  |  |

| **Contraindications that restrict treatment** –*Select if / when appropriate:* | | | | | |
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| Fever |  | Keloid scaring |  | Varicose veins |  |
| Contagious or infectious diseases |  | Skin diseases |  | Pregnancy (abdomen) |  |
| Under the influence of recreational drugs or alcohol |  | Hairy moles |  | Cuts |  |
| Diarrhoea and vomiting |  | Undiagnosed lumps and bumps |  | Bruises |  |
| Mucous membranes |  | Localised swelling |  | Abrasions |  |
| HIV / AIDS |  | Inflammation |  | Scar tissue (2 years for major operation and 6 months for a small scar) |  |
| Anticoagulant drugs |  | Hyperpgimentation |  | Sunburn |  |
| Bell’s palsy |  | Botox / dermal fillers (1 week following treatment) |  | Hormonal implants |  |
| Loss of skin sensation |  | Hypersensitive skin |  | Abdomen (first few days of menstruation, depending on how client feels) |  |
| Haematoma |  | Hernia |  | Recent fractures (minimum 3 months) |  |
| Cervical spondylitis |  | Metal plates |  | Mechanical implants |  |

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| **Written permission required by** – *Either of which should be attached to the consultation form* | | | |
| GP / Specialist |  | Informed consent |  |

# Skin and Hair Tests and Treatment Information

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| Has the client had any previous epilation treatments? | Yes |  | No |  | If yes, for how long? | Enter text. |
| Result of previous treatment (if applicable) | Click or tap here to enter text. | | | | | |
| Any skin reaction? | Click or tap here to enter text. | | | | | |

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| **Present hair and skin condition** – *Select if / where appropriate* | | | | | |
| Normal skin / good healing |  | Erratic / slow to heal |  | Sensitive / prone to reaction |  |
| Dilated capillaries present |  | Oily and blocked |  | Scars present |  |
| Subject to blemishes / cysts |  | Strong / pigmented hair |  | Prone to pigmentation patches |  |
| Dense fine hair |  | Very dry skin |  |  |  |

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| **Area of treatment** – *Select if / where appropriate* | | | | | |
| Face |  | Chest / breast |  | Bikini line |  |
| Abdomen |  | Underarms |  |  |  |

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| **Method of treatment** – *Select if / where appropriate* | | | | |
| Short wave diathermy | |  | Blend |  |
| Intensity used | Click or tap here to enter text. | | | |
| Machine used | Click or tap here to enter text. | | | |
| **Treatment aim and details** – *To include possible reason for hair growth, hair type and reaction to treatment* | | | | |
| Click or tap here to enter text. | | | | |

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| **Client feedback** |
| Click or tap here to enter text. |

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| **Aftercare / home care advice** |
| Click or tap here to enter text. |

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| **Therapist’s signature** |  |

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| **Client’s signature** |  |

# Electrical Epilation – Follow-up Sheet

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| **Treatment details** |
| Click or tap here to enter text. |

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| **Client feedback** |
| Click or tap here to enter text. |

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| **Aftercare / home care advice** |
| Click or tap here to enter text. |

1. Cardiovascular conditions can include: thrombosis, phlebitis, hypertension, hypotension, heart conditions [↑](#footnote-ref-1)
2. Examples of nervous system dysfunctions: multiple sclerosis, Parkinson’s disease, motor neurone disease [↑](#footnote-ref-2)