**A close up of a clock

Description automatically generated\**

**Beauty at Akoya**

**Client Consultation Card**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

D.O.B:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies/medication/medical conditions? List here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you suffer from (Y/N):

Headaches \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Back/Neck Pain \_\_\_\_\_\_\_\_\_\_

Anxiety\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dizziness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Numbness/Tingling\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever reacted to Eyelash Extensions in the past?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a latex allergy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever reacted to Henna?\_\_\_\_\_\_\_\_\_

I understand that on rare occasions allergic reactions may occur to products used during my treatments, I have therefore disclosed all known allergies above and note that refunds will not be issued on completed treatments, if a reaction occurs.

I understand that therapists do not diagnose illness, disease or any other physical or mental disorder; nor do they prescribe medical treatment of any kind. I acknowledge that massage or reiki are not a substitute for medical examination, diagnosis or treatment, and that it is recommended that I see a physician for these services.

**I acknowledge it is my choice to undertake these treatments and I agree to take it upon myself to keep the therapist updated on my health and wellbeing. I understand that there shall be no liability on the practitioner‘s part should I fail to do so.**

**By signing this agreement, I acknowledge that I agree to comply with Akoya’s cancellation policy of the requirement for at least 24 hours notice if I need to change, cancel or if I do not arrive for my appointment. If I do not meet this requirement, a 50% of treatment cost cancellation fee will be payable immediately.**

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_