Hair & Beauty

SPORTS & BEAUTY THERAPY CLIENT RECORD CARD

SURNAME:	
FIRST NAME(S):	
ADDRESS EMAIL	
TEL NO:	
DATE OF BIRTH	
GP's NAME	
GP's ADDRESS	
GP's TEL NO:	

DATE OF CONSULTATION/FIRST VISIT	

I HAVE READ AND UNDERSTOOD ORA REGULATIONS:

SIGNATURE: _____ DATE: _____

Hot/Cold
Sharp/Blunt
Eyelash/Eyebrow Tint
St Tropez PatchTest
Lash Glue

DATE CARRIED OUT

DATE	SKIN TEST DONE	CLIENT SIGNATURE	DATE	SKIN TEST DONE	CLIENT SIGNATURE

Would you like to be added to our mailing list and receive special offers and discounts from ORA Hair and Beauty?

Yes ☐ **Please provide an email address** _____

No ☐

MEDICAL DETAILS

General Health:	
Are you currently or within the last year under a physicians care?	Yes ☐ No ☐ If yes please state _____
Any known allergies	Smoker or Non Smoker
Stress Levels 1-4 (1 – Low Stress, 4 – High)	
Exercise Habits:	
Dietary Habits:	
Recent Operations	
Medication taken at present For what condition	
Do you wear contact lenses	Yes ☐ No ☐

Your Health: ✓ *Tick if applicable*

High/Low Blood Pressure	☐	Heart Trouble/Pace maker	☐
Epilepsy	☐	Diabetes	☐
Blood Related Disorders Etc	☐	Excessive Fillings/Metal Pins or Plates	☐
Thrombosis	☐	Head/ Neck/Back Injuries	☐
Migraine	☐	Body Piercings	☐
Cancer	☐	Contact Lenses	☐
Frequent Coldsore	☐	Skin Conditions	☐
		Any Other Conditions	☐

Please give relevant details

Are you pregnant?

Yes ☐
No ☐

If yes please state how many weeks: _____

FACIAL ANALYSIS

Clients Concerns	
Skin Type	
Skin Texture	
Skin Colour	
Skin Tone	
Muscle Tone	
Skin Conditions	

What skin care products are you currently using?

Soap	❑	Cleanser	❑	Toner	❑		
Moisturiser	❑	Mask	❑	Exfoliator	❑		
Eye Products	❑						

Product range _____

RECOMMENDED PRODUCTS

Cleanser	
Toner	
Exfoliation/frequency	
Moisturiser	
Mask/frequency	
Specialised products For which condition	

General advice

Other recommended salon treatments

MAKE-UP

Face Shape	
Corrective Work	
Foundation Type/Colour	
Face Powder	
Blusher	
Eye Colours/Pencil/Mascara	
Lip Colour/Gloss/Liner	

Other Details

EYE TREATMENTS

Natural Hair Colour	
Brow Shape	
Lash Tint	
Brow Tint	
False Lashes	

WAXING

WAXING TREATMENTS GIVEN				
DATE	**TYPE OF WAX**	**AREA**	**CONTRA-ACTIONS**	**AREA OF CONTRA-ACTION**

MANICURE & PEDICURE

DATE	CONDITION OF NAILS	NAIL SHAPE	CONDITION OF CUTICLES	CONDITION OF SKIN	TREATMENT	ENAMEL COLOUR	THERAPIST NAME

ACRYLICS, GELS

DATE	CONDITION OF NAILS	SYSTEM, IE, ACRYLICS, GELS, WRAPS	CONDITION OF CUTICLES	NAIL SHAPE	ADVISE GIVEN	THERAPIST NAME	SIGNATURE OF CLIENT

FACIAL/ BODY ELECTRICALS

Type	Duration	Intensity	Specialised Products Used	Comments/ Contra-actions

BODY WORK

Client's concerns	

What skin care routine are you currently using?

☐ Soap	☐ Shower Gel	☐ Scrubs
☐ Oil	☐ Body Moisturiser	
☐ Depilatory Products	☐ Self Tanners	

Areas of good muscle tone		Areas of poor muscle tone	
Areas of hard fat		Areas of soft fat	
Areas of cellulite			
Frame Size/Wrist Measurement		Body Type	
Height		Weight	

Posture
Skin Condition

Recommended treatments (with reasons for choice)

General advice

TRUNK	WEEK/DATE			
Sub Axilla (above bust)				
Inferior angle of scapula ((bust)				
Waist				
Anterior lilia Spine (ASIS) (hips)				
Great Trochanter (bottom)				
LOWER LIMB	L R	L R	L R	L R
6” above Patella (above knee)				
Around superior surface of Patella (knee)				
Widest part of gastrocnemius (calf)				
Med, lat, malleolus (ankle)				
UPPER LIMB	L R	L R	L R	L R
4” above olercranon process (above elbow)				
Olecranon process (elbow)				
3” below olecranon process (below elbow)				
Around Styloid process of radius (wrist)				

DATE	**ACTUAL WEIGHT**	**WEIGHT**	
		LOSS	**GAIN**

DATE	TREATMENT	COMMENTS CONTRA ACTIONS OBSERVED	THERAPIST NAME

DATE	TREATMENT	COMMENTS CONTRA ACTIONS OBSERVED	THERAPIST NAME

DATE	TREATMENT	COMMENTS CONTRA ACTIONS OBSERVED	THERAPIST NAME