the Medical Spa at CAPSTONE

Lash Client Information

Name:_____ Date:_____

Birth date:_____ How did you hear about us?_____

Cell Phone:_____ Text reminders ok? YES / NO

Email:_____

PLEASE ANSWER THE FOLLOWING QUESTIONS, WHICH MAY AFFECT THE AMOUNT OF TIME YOUR EXTENSIONS WILL LAST

Have you ever had eyelash extensions before?	YES	NO
If yes, was it a good experience?	YES	NO
Where did you previously have them done?	_____	
Do you sleep on your face or stomach?	YES	NO
Do you have oily skin?	YES	NO
Do you attend “Hot Yoga”?	YES	NO
Do you get facials?	YES	NO
Do you ever rub or itch your eyes?	YES	NO
Do you have sensitive skin or allergies?	YES	NO
Do you spray tan?	YES	NO
Do you wear eyeliner?	YES	NO
Do you use prescribed eye medication?	YES	NO

If yes, name of medication: _____ How Often: _____

CIRCLE BELOW WHAT YOU WOULD LIKE TO ACHIEVE:

Natural Slightly Longer Dramatic