CONSULTATION FORM(PLEASE FILL THIS BEFORE APPOINTMENT)

Giana Ltd takes privacy seriously. As the data controller of the personal data that you provide on this form, we will use your personal data for the purposes of carrying out your consultation and keeping a record of your treatments. Please refer to our full privacy policy on www.giana.life for more information about your rights and how we use your personal data. If you have any questions, please use the Contact Us function at www.giana.life.

I consent to the Giana Group using my personal data to contact me using the methods set out below to advise me of new products, and to provide me with special offers and product information.

SMS (text) ☐ phone ☐ post☐ email ☐

You can opt-out at any time by clicking on the unsubscribe link we provide in our communications or by using the Contact Us function at www.giana.life.

A .PERSONAL

FULL NAME :

HOME ADDRESS :

DATE OF BIRTH:

EMAIL:

TELEPHONE NO:

CHOSEN METHOD OF CONTACT:

B. HEALTH HISTORY:

1. Are you currently taking any prescription medication or under doctors' care ? YES / NO

If Yes, please list:.....

2. Do you suffer from or have you experienced any of the following ?

Diabetes Yes/No Skin disorders Yes/No Kidney problems Yes/No

Limitation of body movement/arthritis Yes/No Are you pregnant Yes/No

Epilepsy Yes/No Prone to keloid scarring Yes/No Hormone imbalance Yes/No

Stroke Yes/No Claustrophobia Yes/No Hepatitis Yes/No HIV Yes/No

Recent scar tissue/surgery Yes/No Cold sores Yes/No Respiratory problems Yes/No

Blood Pressure Yes/No High/low blood pressure Yes/No Operations within 6 months Yes/No

3.*Any other medical conditions/ailments Yes/ No

IF YES, Please specify

_____

4. Do you have any known allergies Yes/ No

If Yes ,please state.....

5. Are you pregnant or planning a pregnancy ? Yes/ No

6.Do you have any metal implants ,body piercings or pacemaker ? Yes / No

C. NUTRITION AND LIFESTYLE

7. What percentage of your daily diet is fresh food ? .....%

8. What percentage of your average diet is processed food ?.....%

9. How many of the following do you consume on a daily basis ?

Coffee..... Tea..... . Fizzy drinks..... Water..... Alcohol.....

10. How often do you exercise?.....

11. What do you do to relax?.....

12. What is your current occupation?.....

13. On a scale of 1-10 how would you rate your current stress level .....

14. Would you say your sleep patterns are : Adequate..... Not Enough..... Plenty.....

15. Have you been sunbathing recently : Yes/ No

D. YOUR SKIN

16. Do you experience : Flakiness... Tightness.... Redness... Breakouts.... Oily Shine....

Pigmentation..... Lines/ wrinkles..... Dryness.....

17.What is your specific concern about your skin?.....

18. What improvements do you wish to see?.....

E. SKINCARE PRODUCTS

19. Which of the following are currently using? Mark all that apply

Cleanser..... Exfoliant.....Masque..... Serum.....Toner.....Moisturiser.....SPF..... Make-Up.....

Body Moisturiser/cream ..... Body brushing..... Oils..... Other:.....

F. PREVIOUS INVASIVE TREATMENTS

20. Have you ever had the following treatments? If so please mark the latest treatment date :

Botox:..... Dermal Fillers: ..... Chemical Peel:..... IPL/Laser:..... Facial Waxing:.....

Micro-dermabrasion..... Face Shaving:..... Microblading.....

G. DECLARATION

I confirm to the best of my knowledge that the answers I have given are correct and that I have not withheld any information that may be relevant to the treatment. I have read the Privacy Notice regarding the collection of Health information and consent to my health information being processed for the purposes of determining the safety of treatments as described in the privacy Notice. In addition to the health information provided ,further information may be required for certain procedures.

SIGNATURE: Date:

H. TREATMENT RECORD (TO BE FILLED BY THERAPIST)

DATE	MEDICAL UPDATES/ OTHER NOTES	TREATMENT RECEIVED /PRODUCTS USED/RECOMENDATIONS	THERAPIST/ INTITIALS