

CLIENT INFORMATION

Full Name	Date of Birth	Date
Email	Phone	
Emergency Contact	Emergency Phone	

MEDICAL SCREENING

Please answer all questions honestly. Certain conditions may affect suitability for treatment or require additional precautions.

CONDITION	YES	NO	DETAILS (IF YES)
History of cold sores (HSV-1)			
Active cold sore or lip infection			
Pregnant or breastfeeding			
Isotretinoin / Accutane (current or past 6 months)			
Blood thinners (warfarin, aspirin, heparin)			
Diabetes (Type 1 or 2)			
Autoimmune condition			
Keloid or hypertrophic scarring history			
Eczema, psoriasis, or dermatitis near lip area			
Allergies (latex, metals, topical anaesthesia)			

Current medications (list all)

FILLER & PMU HISTORY

Have you had lip filler?

Never Previously (dissolved) Currently have filler

Last filler date	Product used	Injector name
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Previous lip PMU?

No Yes — satisfied Yes — seeking correction

If yes: when, where, and what technique?

LIFESTYLE & GOALS

What result are you hoping to achieve?

Subtle tint Natural blush Defined colour Full coverage Border definition Colour correction

Colour preference	Daily lip product use
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Available for follow-up sessions?

Yes — flexible Limited (1-2 only) Single session only

Upcoming events or holidays within 6 weeks?

ANTIVIRAL PROPHYLAXIS

- Prophylaxis prescribed and started (date: _____)
- Client declines — risks explained
- N/A — no HSV-1 history (still recommended)

PRACTITIONER NOTES

Assessment summary / contraindication flags / archetype recommendation

Client Signature

VELONÉ Blush Academy · velonepmu.com/blush

Practitioner Signature

Date

Confidential Client Record · VB-FORM-001