VELONÉ
BROW ACADEMY

Client Assessment Form

Professional Documentation

Client Information

Full Name: _____ Date: _____

Date of Birth: _____ Referred By: _____

Phone: _____ Occupation: _____

Email: _____ Emergency Contact: _____

Medical History & Contraindications

- ☐ Diabetes
- ☐ Keloid Scarring
- ☐ Blood Disorders
- ☐ Skin Conditions
- ☐ Autoimmune Disease
- ☐ Pregnancy/Nursing
- ☐ Recent Skin Treatments
- ☐ Medications (list below)
- ☐ Allergies (list below)

Current Medications: _____

Known Allergies: _____

Skin Assessment

Fitzpatrick Skin Type: ○ I ○ II ○ III ○ IV ○ V ○ VI

Skin Texture: ☐ Normal ☐ Oily ☐ Dry ☐ Combination ☐ Sensitive

Previous Brow Work

☐ None ☐ Microblading ☐ Powder Brows ☐ Combination ☐ Tattoo ☐ Other

If previous work, date performed: _____ By: _____

Condition of previous work: _____

Style Consultation

Recommended Model: ☐ Classic ☐ Soft Harmony ☐ Elevated ☐ Expressive ☐ Modern Edge

Client's Style Preferences: _____

_____

Consent & Acknowledgment

I confirm that the information provided is accurate. I understand the procedure, potential risks, and aftercare requirements. I consent to the proposed treatment and release the practitioner from liability for any complications arising from undisclosed information.

Client Signature: _____ Date: _____

Practitioner Signature: _____ Date: _____