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CLIENT INFORMATION AND CONSENT FORM: SKIN CARE

Name _____ Date of Consultation _____

Address _____

City _____ State _____ Zip _____

Home phone (_____)_____ Cellular phone (_____)_____

E-mail _____ Date of birth _____

Emergency contact and telephone number _____

How did you find out about us? Name of person / website / other: _____

1. What is your goal for today's visit and/or future visits? _____

2. Are you using any blood/skin thinning products and/or drugs? ❑ Yes ❑ No

3. Are you exposed to the sun daily or are you considering spending more time in the sun soon? ❑ Yes ❑ No

4. Do you use a tanning bed? ❑ Yes ❑ No If yes, how often & last time: _____

5. Have you been under care of a dermatologist or other medical professional in the last year? ❑ Yes ❑ No

If yes, please explain: _____

6. Have you used an acne medication? ❑ Yes ❑ No If yes, when? _____ Which drug? _____

7. List any other medications you are presently taking: _____

8. List any over-the-counter medications (including vitamins, herbal supplements, aspirin, etc.) that you take regularly: _____

_____

9. Please list any other illness or condition you are currently being treated for by a medical professional: _____

_____

10. Have you had any recent surgery, including plastic surgery? ❑ Yes ❑ No

If yes, please explain: _____

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11. Have you ever been treated for cancer? ❑ Yes ❑ No

If yes, when and what types of therapies were used?: _____

_____

12. Do you smoke? ❑ Yes ❑ No

13. Do you follow a restricted diet? ❑ Yes ❑ No

If yes, please explain: _____

14. Do you follow a regular exercise program? ❑ Yes ❑ No

15. List your daily consumption of: Water _____ Caffeine _____ Alcohol _____

16. Do you form thick or raised scars from cuts or burns? ❑ Yes ❑ No

17. Do you have hyperpigmentation (darkening of the skin) or hypopigmentation (lightening of the skin) or

marks after physical trauma? ❑ Yes ❑ No If yes, please explain: _____

_____

18. What is your stress level? ❑ High ❑ Medium ❑ Low

19. Do you experience any problems sleeping? ❑ Yes ❑ No

20. How many hours do you sleep each night? _____

21. Do you wear contact lenses? ❑ Yes ❑ No

22. Do you have any metal implants or wear a pacemaker? ❑ Yes ❑ No

23. Have you had any piercings, tattoos, or permanent makeup? ❑ Yes ❑ No

If yes, where on your person?: _____

24. Do you suffer from: Claustrophobia? ❑ Yes ❑ No Sinus problems? ❑ Yes ❑ No

25. Are you taking oral contraceptives? ❑ Yes ❑ No If yes, please specify: _____

Any recent changes to or from your contraceptive treatment? ❑ Yes ❑ No If yes, when: _____

26. Are you pregnant or trying to become pregnant? ❑ Yes ❑ No Are you lactating? ❑ Yes ❑ No

27. Do you have any problems relating to menopause? ❑ Yes ❑ No If yes, please explain: _____

_____

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28. Have you ever had an allergic reaction to any of the following? (Please check all that apply and explain)

❑ Cosmetics ❑ Medicine ❑ Food ❑ Animals ❑ Sunscreens ❑ Iodine ❑ Pollen

❑ AHAs ❑ Fragrance ❑ Shellfish ❑ Latex ❑ Drugs ❑ Other: _____

If yes, please explain: _____

29. Have you used any Alpha Hydroxy Acid (AHA) or glycolic products in the past week? ❑ Yes ❑ No

30. Are you using/have you used Retin-a, Renova, Accutane, Adapalene, Differin, Retinol, or Vitamin A derivative products ? ❑ Yes ❑ No

31. Have you ever had any adverse reactions to a skin care treatment or product? ❑ Yes ❑ No

If yes, please explain: _____

32. Have you ever had an adverse reaction after using any skin care product?

❑ Rash ❑ Irritation ❑ Peeling ❑ Sun sensitivity ❑ Breakout

If yes, please explain: _____

33. Have you had any of these health conditions in the past or present?
(Please check all that apply and provide additional information in the space provided)

__Cancer
__Hormone imbalance
__Systemic disease
__High blood pressure
__Spinal injury
__Thyroid condition
__Hysterectomy
__Diabetes
__Heart problem
__Varicose veins
__Arthritis
__Eczema/Psoriasis
__Epilepsy
__Seizure disorder
__Fever blisters
_Hepatitis
__Herpes
__Frequent cold sores
__Immune disorders
__HIV/AIDS
__Lupus
__Metal bone pins or plates
__Phlebitis, poor circulation
__Blood clotting
__Asthma
__Psychological treatment
__Skin diseases/skin lesions
__Insomnia
__Keloid scarring
__Skin disease/skin lesions
__Headaches (chronic)
__Any active infection

Explanation of above or any additional information: _____

_____

_____

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Please note that skin care treatments can have certain side effects, such as redness, rash, swelling, tenderness, etc.

I have read the above information and if I have any concerns, I will address these with my Skin Care Professional (SCP). I give permission to my SCP to perform the skin care procedure we have discussed and will hold her and her staff harmless from any liability that may result from this treatment. I have given an accurate account of the questions asked above including all known allergies or prescription drugs or products I am currently ingesting or using topically. I understand my SCP will take every precaution to minimize or eliminate negative reactions as much as possible.

I have read and understand the post-treatment home care instructions. I am willing to follow recommendations made by my SCP for a home care regimen that can minimize or eliminate possible negatives reactions. In the event that I may have additional questions or concerns regarding my treatment or suggested home products/ post-treatment care, I will consult the SCP immediately.

I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read, and fully understand the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered. I understand the procedure and accept the risks. I assume all risks and outcomes of treatements and use of products. I do not hold the SCP, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this skin care procedure, which may be affected by the treatment performed today.

Client Name (printed) _____

Client Name (signature) _____Date _____

Skin Care Professional _____Date _____