SOUTH BAY LIPO LIGHT

MICROCURRENT INTAKE FORM

Your success is our #1 priority.

Help us to help you achieve that success by filling out this questionnaire as completely as possible.

Name:_____Date:_____

Address:_____

Home #:_____ Work #: _____ Cell #:_____

Email: _____Age:_____ Sex:____

Occupation:_____Marital Status:_____

Are you stressed? (Y/N) Cause of Stress: _____
List any current or previous medical conditions that might affect you having this treatment
_____

Do you have any of the following? (Any of the following would make you unsuitable):

____ Pregnant or Breastfeeding
____ Thyroid Problems
____ Light Sensitivity
____ Light Sensitivity
____ Taking Tetracycline

Medical History (Circle any that apply):

Acne, Any Active Infection, AIDS/HIV, Allergies, Arthritis, Autoimmune Disease, Blood clot abnormalities, Broken Capillaries, Cancer, Carcinoma, Cold Sores, Dermatitis, Diabetes, Eczema, Hepatitis, Herpes Simplex, Hormone Imbalance, HRT, Implants, Injectable, Keloid Scarring, Metal in Body, Pacemaker, Permanent Make-up, Photosensitivity, Tattoos, Telangiectasia, Thyroid Imbalance

Skin Condition

Are you currently under the care of a physician? (Y/N)
For What _____
Are you currently under the care of a dermatologist? (Y/N)
For What _____
What bothers you about your skin?_____
Current Skincare Products used _____
Circle any of the following products currently being used by you

Retin A: How Often ____ Where Applied_____
Accutaine: How Often ____ Where Applied_____
Glycolic AHA: How Often ____ Where Applied_____
Any skin reaction to the above _____
Have you ever had a reaction to any products (if yes, describe)? (Y/N)

_____

Have you had a peel before? (Y/N) If yes, when? _____ What Type _____

Describe skin reaction to the peel _____

Please circle the following Yes or No

Is your skin Sensitive or Resilient? (Y/N)

Have you recently used self-tanning lotions?(Y/N)

Do you go to tanning booths? (Y/N) Have you tanned within last 4 weeks? (Y/N)

Do you currently have sunburn or windburn? (Y/N)

Do you get thick or raised scars from cuts or burns? (Y/N)

Do you have hyperpigmentation (darkening of the skin)? (Y/N) Describe _____

Do you have hypopigmentation (lightening of the skin)? (Y/N) Describe _____

Have you had any filler injections within the last 7 days? (Y/N)

Have you ever had an allergic reaction to the following? (Circle and describe)

Aloe Vera, Apples, Aspirin, Citrus, Food, Grapes, Hydrocortisone, Hydroquinone(or skin bleaching), Latex, Lidocaine, Other

Describe Reaction _____

Are you taking any of the following medications? (Circle and describe)

Acutane, Anti-depressants, Antiviral, Aspirin, Cortizone, Coumadin, Dilantin, Estrogen, Herbs, Medications, Minerva, Minoxidile, Progesterone, Spironolactone, Testosterone, Tomoxfin, Vanica, Yaz

Other Medication _____

Do you smoke? (Y/N) Cups of Water you drink per day? _____

How did you find us? _____

Who may we thank for the referral? _____

Is there anything relevant that you need to let us know? _____

_____

Circle the most important element in deciding to use our services (check one):

___ Effectiveness (your results)

___ Time (how fast you get results)

___ Service (how we respond to your needs)

___ Affordable (what we charge)

You should note that if the therapist is unable to explain to you the contra indications or is unsure of anything that may apply to a specific condition then they should not treat you without asking you to consult with your primary physician. It is your responsibility and not that of PWLC staff to consult your primary physician if necessary. I hereby indemnify the therapist against any adverse reaction sustained as a result of the treatment and confirm that all the information I have given regarding medical, personal, and skin history statements are true and correct are correct, and that it is my responsibility to inform the technician performing this procedure of my current medical and health conditions. *By signing this, you also acknowledge there is a strict 24 hour cancellation policy.*

Signed..... Date...../...../.....

LIPO LIGHT SOUTH BAY OFFICE ONLY Initial Consult Date: _____

Last Name _____ First Name _____ F M

Sessions Purchased _____

Adequate Water Intake (Y/N)
Concerns _____

_____

_____