

**Client Information**

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check all that apply:

* Are you pregnant?
* Are you trying to get pregnant?
* Do you have an allergy to shellfish?
* Do you have any other allergies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Do you use an EPI Pen?
* Do you have metal implants?
* Do you have any heart problems?
* Do you have a pacemaker?
* Do you have high/low blood pressure?
* Do you have Epilepsy or a seizure disorder?
* Have you had any recent chemotherapy or radiation?
* Do you smoke?
* Are you currently under a Doctor’s care?
* Please list all of your current medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your skin care regimen?

\_\_\_Soap \_\_\_Cleanser \_\_\_Toner \_\_\_Exfoliator \_\_\_Mask \_\_\_Serum \_\_\_Moisturizer \_\_\_Sunscreen

Do you use any products that contain any of the following ingredients?

\_\_\_Retinoid (Vit A) \_\_\_Glycolic Acid \_\_\_Alpha Hydroxy Acid \_\_\_Salicylic Acid \_\_\_Lactic Acid

\_\_\_Accutane (or other acne drug) \_\_\_Benzoyl Peroxide Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any of the following skin issues?

\_\_\_Rosacea \_\_\_Dermatitis \_\_\_Eczema \_\_\_Psoriasis \_\_\_Recent Sunburn Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your stress level (1-5, 5 being very stressful)? \_\_\_\_\_\_

Have you ever experienced any of the following (date of last procedure)?

Microdermabrasion \_\_\_\_\_\_\_ Electrolosis \_\_\_\_\_\_\_\_ Waxing \_\_\_\_\_\_\_ Chemical Peel \_\_\_\_\_\_\_\_ Laser \_\_\_\_\_\_\_\_ Depilatories \_\_\_\_\_\_\_\_ Injectables \_\_\_\_\_\_\_\_ Botox \_\_\_\_\_\_\_\_

**Consent for Treatment**

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the treatment may be adjusted to my comfort. I further understand that facial treatments should not be construed as a substitute for medical examination or diagnosis. I affirm that I have stated all my known medical conditions and answered all questions honestly and understand that there shall be no liability on the practitioner’s part should I fail to do so. Understanding all of this, I give my consent to receive care.

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_