BODYBRITE

CLIENT INFORMATION AND MEDICAL HISTORY

Welcome to BodyBrite! In order to provide you with the most appropriate treatments, we need you to complete the following client form. All information is strictly confidential. During your consultation we can answer any concerns or questions about information in this form.

How did you hear about BodyBrite?:_____

Who referred you to us? We'd like to thank them: _____

PERSONAL HISTORY

Name: _____ Date: _____

Address: _____ Date of Birth: _____

City State Zip: _____

Email: _____

Mobile Phone: _____

Emergency Contact & Phone: _____

Primary Care Doctor & Phone: _____

MEDICAL HISTORY

1) Are you currently under the care of a physician? Yes/ No
If yes, for what:

_____

2) Are you currently under the care of a dermatologist? Yes/ No
If yes for what:

_____

3) What diseases run in your family?

_____

4) Have you ever undergone any Botox or filler (Hyaluronic Acid, Collagen, own fat, or others) material treatments? Yes/ No
When and body area:

_____

5) Do you have any implants, dental implants, fillers, metal implants, stents, skin grafts, tattoos or permanent makeup in the areas to be treated? Yes/ No
Body area:

_____

6) Are you pregnant or breastfeeding? Yes/ No

MEDICATIONS

7) What oral medication are you presently taking? Please list all including oral contraceptives, vitamins, herbal supplements and painkillers. (e.g. Aspirin, Ibuprofen, etc.)

_____

8) What topical medications or creams are you currently using? (E.g. Retin-A, Vitamin A)

_____

9) Have you used recreational drugs in the past 24 hours? Yes/ No

10) Have you used oral isotretinoin (Accutane) within the past 6 /12 months? Yes/ No

CONDITIONS THAT MAY IMPACT OUR TREATMENTS

11) Have you experienced or been treated for any of the following, currently or in the past?

- ☐ Cancer
- ☐ Herpes
- ☐ Epilepsy
- ☐ Asthma
- ☐ Heart Disease
- ☐ Polycystic Ovaries
- ☐ Lupus
- ☐ Lung disorder
- ☐ Fainting/Seizures
- ☐ Venereal disease
- ☐ Hormonal disorders: *Hirsutism/Hypertrichosis*
- ☐ Varicose Veins
- ☐ Auto immune Skin Disorders
- ☐ Internal Defibrillator
- ☐ Chemotherapy/Radiotherapy
- ☐ Thyroid Disease
- ☐ Diabetes I ☐Diabetes II
- ☐ Keloids
- ☐ Kidney Disease
- ☐ HIV/ AIDS
- ☐ Porphyria
- ☐ Stomach problems
- ☐ Drug or Alcohol problems
- ☐ Cold sores
- ☐ Bleeding/Clotting Problems
- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ Pacemaker

SKIN RELATED CONDITIONS

- ☐ Sun Rash
- ☐ Melasma
- ☐ Rosacea
- ☐ Hypopigmentation
- ☐ Active dermatitis/wounds
- ☐ Skin Disorders
- ☐ Actinic Keratosis
- ☐ Stretch marks
- ☐ Plymorphous light-induced rash
- ☐ Acne
- ☐ Hyperpigmentation
- ☐ Psoriases
- ☐ Vitiligo
- ☐ Moles
- ☐ Scars

DENTAL RELATED CONDITIONS

- ☐ Gum sensitivity
- ☐ Receding gums
- ☐ TMJ/TMD (limited mouth opening)
- ☐ Any oral disease (cavity/root canal/ gingivitis)
- ☐ Other (specify)_____

12) If you marked any of the above please give us more detailed information here, including dates: _____
_____

13) Do you have any other health problems or medical conditions? Please list below:
_____

14) List any surgeries (such as cosmetic, breast biopsy, C-section, etc.) over the last 2 years:
_____

SKIN RELATED

1) Are you allergic to iodine, latex, peroxide, glycerin or any medications? Yes/No
List: _____

2) Have you had a skin peeling service? Chemical? Please specify and date bellow.
_____

3) Are you tanned? Yes/ No 4) If yes, which body area? _____

5) Which tanning method? (circle): Sun Tanning Beds Lotion Spray

6) When was the last time you were exposed to the sun? _____

7) When do you intend to be exposed to the sun again? _____

8) Do you currently wear a sun protection product all day, every day? Yes/ No

9) Are you willing to wear a sun protection product all day, every day? Yes / No

10) Have you done any aggressive exfoliation to your skin in the last 2 weeks? Yes/No
If yes, name type(s) of exfoliation: _____

11) Would you describe your skin as: SENSITIVE AND INTOLERANT OR DRY SKIN

12) Does your skin ever get flaky or itch? Yes/No
If yes, is it seasonal or all the time?_____

DENTAL HISTORY

1) Have you ever had Teeth Whitening done? Yes/No
If yes, when and what method _____

2) How often do you go to the dentist? _____ 3) Last Visit _____

4 Do you have teeth sensitivity? Yes/No

5) Do you smoke? Yes/ No 6) Do you drink coffee? Yes/ No

7) Do you use, used or intend to use braces? Yes/No Dates: _____

TREATMENTS

1) Have you ever had IPL or laser hair removal? Yes/ No

2) Have you had any of the following hair removal methods done in the past 2-4 weeks (*in the body areas where you'd like to be treated*)? Please Circle Below:
Shaving Waxing Electrolysis Tweezing Threading Depilatory Creams

3) Have you ever done, or are you currently doing any aesthetical treatment?
Please specify treatment name:

A) Treatment _____
Starting Date_____
Ending Date_____
Number of sessions_____
Results (expected, not expected, etc.)
_____

B) Treatment _____
Starting Date_____
Ending Date_____
Number of sessions_____
Results (expected, not expected, etc.)
_____

C) Treatment _____
Starting Date_____
Ending Date_____
Number of sessions_____
Results (expected, not expected, etc.)
_____

SERVICES WISH LIST

What Treatments are you interested in:

- ☐ IPL Hair Removal
- ☐ IPL SR Removal
- ☐ TW Teeth Whitening
- ☐ Oxygen Treatment (Hyaluronic acid)
- ☐ Microdermabrasion
- ☐ Facial. Specify:_____
- ☐ BodySculpt - Body: Contouring/Skin Tightening/Cellulite Reduction
- ☐ BodySculpt - Face: Skin Tightening/Wrinkles Reduction
- ☐ Only came in for buying products. Products: _____
- ☐ Only came in for an event. Event: _____
- ☐ Other _____

What areas of the body are you interested on having treated:

- ☐ FACE
- ☐ NAPE
- ☐ CHEST
- ☐ DECOLLETE
- ☐ ABDOMEN
- ☐ UNDERARMS
- ☐ UPPER ARMS *(2 zones)*
- ☐ LOWER ARMS *(2 zones)*
- ☐ HANDS
- ☐ SHOULDERS
- ☐ UPPER BACK
- ☐ LOWER BACK
- ☐ BIKINI
- ☐ BRAZILIAN (2 zones, includes bikini line & perineum)
- ☐ GROIN (men)
- ☐ BUTTOCKS (includes perineum)
- ☐ UPPER LEGS *(2 zones)*
- ☐ LOWER LEGS *(2 zones)*
- ☐ Other (specify)_____

If you need, ask us for the list further detailing the body zones.

Starting today with:

_____

ACKNOWLEDGEMENT:

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the esthetician or staff of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures. I also authorize BodyBrite to make a copy of my identification to be kept in my client chart.

I know that this form may have attached a consent form and further information according to the treatment I will have performed and that it also needs to be read and signed.

I was totally informed about the before and after care.

All my questions and concerns were properly answered by:

_____ (Esthetician/Nurse)

_____ Date: _____
Client Signature (Parent/Guardian if a minor)

IPL HAIR REMOVAL:

I was informed that some areas of the body take more treatments sessions than do others and also that there is no determined number of sessions due to the dependence of innumerous factors.

_____ Date: _____
Client Signature (Parent/Guardian if a minor)

CANCELATION:

24 Hours notice, via phone, email or online booking is requires for all cancellations or the full appointments fee may be charged.

I have read, understood and agree with the cancelation policy terms.

SIGNATURE_____

- **A complementary Consultation Form is part of the BodyBrite experience. We want to know you better and understand how to meet your needs by offering you the most appropriate solution for your well being and goals.**