

## 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?

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

## SKIN RELATED CONDITIONS

- |   |  |
|---|--|
| <input type="checkbox"/> Sun Rash                 | <input type="checkbox"/> Polymorphous light-induced rash |
| <input type="checkbox"/> Melasma                  | <input type="checkbox"/> Acne                            |
| <input type="checkbox"/> Rosacea                  | <input type="checkbox"/> Hyperpigmentation               |
| <input type="checkbox"/> Hypopigmentation         | <input type="checkbox"/> Psoriasis                       |
| <input type="checkbox"/> Active dermatitis/wounds | <input type="checkbox"/> Vitiligo                        |
| <input type="checkbox"/> Skin Disorders           | <input type="checkbox"/> Moles                           |
| <input type="checkbox"/> Actinic Keratosis        | <input type="checkbox"/> Scars                           |
| <input type="checkbox"/> Stretch marks            |  |

## DENTAL RELATED CONDITIONS

- |   |  |
|---|--|
| <input type="checkbox"/> Gum sensitivity                                  | <input type="checkbox"/> Receding gums |
| <input type="checkbox"/> TMJ/TMD (limited mouth opening)                  |  |
| <input type="checkbox"/> Any oral disease (cavity/root canal/ gingivitis) |  |
| <input type="checkbox"/> 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:  
\_\_\_\_\_

# BODYBRITE

## 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.) \_\_\_\_\_

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C) Treatment \_\_\_\_\_  
 Starting Date \_\_\_\_\_  
 Ending Date \_\_\_\_\_  
 Number of sessions \_\_\_\_\_  
 Results (expected, not expected, etc.) \_\_\_\_\_

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## 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:

- |  |   |
|--|---|
| <input type="checkbox"/> FACE                  | <input type="checkbox"/> BIKINI   |
| <input type="checkbox"/> NAPE                  | <input type="checkbox"/> BRAZILIAN (2 zones, includes bikini line & perineum) |
| <input type="checkbox"/> CHEST                 | <input type="checkbox"/> GROIN (men)  |
| <input type="checkbox"/> DECOLLETE             | <input type="checkbox"/> BUTTOCKS (includes perineum)                         |
| <input type="checkbox"/> ABDOMEN               | <input type="checkbox"/> UPPER LEGS (2 zones)                                 |
| <input type="checkbox"/> UNDERARMS             | <input type="checkbox"/> LOWER LEGS (2 zones)                                 |
| <input type="checkbox"/> UPPER ARMS (2 zones)  |   |
| <input type="checkbox"/> LOWER ARMS (2 zones)  |   |
| <input type="checkbox"/> HANDS                 |   |
| <input type="checkbox"/> SHOULDERS             |   |
| <input type="checkbox"/> UPPER BACK            |   |
| <input type="checkbox"/> LOWER BACK            |   |
| <input type="checkbox"/> Other (specify) _____ |   |

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

**Starting today with:**

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## 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)

\_\_\_\_\_  
Client Signature (Parent/Guardian if a minor)

Date: \_\_\_\_\_

## 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 innumerable factors.

\_\_\_\_\_  
Client Signature (Parent/Guardian if a minor)

Date: \_\_\_\_\_

## CANCELATION:

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

I have read, understood and agree with the cancellation 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.**