Client Questionnaire

Patient Information

Date_______________________

Name_________________________________ Date of Birth_____________________

Address ____

Primary Phone_____________________ Occupation___________________________

Does Your Job Require You Work Outdoors? Y N

Referred by____

What do you hope to achieve from your treatment today?

____

Your Skincare Routine

What products do you use on your skin?

____

____

____

____

Which of the following best describes your skin type?

I Creamy Complexion Always Burns Easily, Never Tans

II Light Complexion Always Burns, Tans Slightly

III Light/Matte Complexion Burns Moderately, Tans Gradually

IV Matte Complexion Seldom Burns, Always Tans Well

V Brown Complexion Rarely Burns, Deep Tan

VI Black Complexion Never Burns, Deeply Pigmented

Are you of Asian heritage (Class V) and/or have a history of keloid scarring? Yes No

Do you have history of keloid scarring? Y N

Do you have any specific problems or concerns with your skin?

____

____

Have you had any skin treatments in the last month, including peels, waxing, laser, microdrermabrasion, or injections? ____

Do you use Retin-A Renova, Differin or other Hydroxyl/Vit A derivatives on your skin? Y N
If yes, when was it last applied?

____

Do you have any allergies? Y N
If so, please list them:____

____

Are you or have you ever been on accutaine? Y N   If yes, when?_____________________

Are you on any prescription acne meds? Y N. If so, which ones___________________

Have you ever had any of the following Y N (circle all that apply)
Chemical Peel/Exfoliation Botox Dermal Fillers Tattoo/Permanent Make-Up Waxing
Laser Treatments. Facial Surgery Microdermabrasion Dermaplaning Facials.
Microneedling Cool Sculpting

Please share details of treatments you've had...results, dates etc.

____

____

Have you ever had cold sores/fever blisters? If so, when was the last one? And how often do you get them? ____

Please list any medications you are taking

____

____

How would you describe your skin? (Circle All That Apply and add any not on the list)

Dry Oily Combination Fine Lines Deep Wrinkles Puffy Acne Scars Rosacea
Dark Circles Sensitive ____

Do you use sunscreen regularly? Y N

Are you pregnant or trying to get pregnant? Y N

Are you lactating? Y N

Are you experiencing menopause symptoms? Y N
Please list ____

Folllow Up

Can I call you at the number you provided our office to confirm appointments? Y N

May I contact you via email about future promotions and events? Y N
Email you'd like us to use______________________________________

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof.

Clients Name	Clients Signature	Date

For Clients Under the age of 18

Guardian Name and Relationship to Patient	Guardian Signature	Date

For Treating Personnel

Treating Personnel Name	Signature	Date

Consent to Advanced Aesthetic Treatments

Technician ____

This Informed Consent to Treat applies to two classifications of Esthetics care:

Advanced Esthetics Services and Esthetic Classic Services.
Check the type of esthetic services below applicable to you.
Check both if you anticipate receiving treatment under both categories.
Consult your technician if you have questions about the nature of treatment anticipated for you:

☐ Advanced Esthetic Services: Which includes Esthetic peels up to 40%, electrology, needling/collagen induction therapy, non-invasive ultrasound, and hand-held cryotherapy.

☐ Esthetic Classic Services: Which includes Body contouring, cellulite reduction, radio frequency, and high frequency treatments

- I elect to receive the esthetics procedure(s) indicated above.
- I declare that I am over the age of 18, not under the influence of drugs or alcohol, not pregnant or nursing, not on blood thinners or blood pressure medication, and am not an insulin- dependent Diabetic.
- I understand that if I am under the age of 18, Parental Consent is required for me to obtain these procedures. Under no circumstances may I have these services if I am under the age of 14. I represent that the stated date of birth is truthful on this form.
- I understand that many medications and some diseases and disorders may either contraindicate me for treatment or affect the results.
- I understand I should continue taking my medications, and tell my technician about all prescription and non-prescription drugs, supplements, topically applied products, eye drops, etc. that I use or take.
- I understand that due to the nature of this treatment, results cannot be predicted, and I acknowledge that no guarantees have been made as to the results that may be obtained.

Warning: Treatment is not available to clients who are on Accutane. Clients using anticoagulants must disclose this to the Technician, as treatment may need to be modified to mitigate additional risk associated with the use of these drugs. Clients with a pacemaker, internal defibrillator, or metal implants must disclose this to the Technician as this may contraindicate them for treatment.

For women of childbearing age: You confirm that you are not pregnant and do not intend to become pregnant during the course of treatment. Furthermore, you must keep your technician informed should you become pregnant during the course of treatment.

Pre-Procedure and Aftercare Instructions:

I have received, and will strictly adhere to, all pre-procedure and aftercare instructions.

I understand that for those with more color in the skin, it is advised to use a lightening agent leading up to the procedure to suppress the melanin in the skin.

I understand there may be an extended period of recovery following the procedure(s), and that aftercare compliance is crucial for healing, prevention of scarring, hyper-pigmentation and hypo-pigmentation.

I understand that particularly avoiding sun exposure after the procedure is crucial to reduce the risk of color change and will always apply a broad spectrum SPF 25 or higher, as recommended by my technician.

I understand that initially, the skin treated may be red and swollen, that fine, thin scabs may form, and that the healing process typically takes anywhere from one to three weeks. However, I am aware that in rare cases, depending on my skin sensitivity and recovery capacity, healing could take as long as three to six months.

General Risks of Procedure(s):

I understand there are risks associated with my procedure, including, but not limited to: minor burns, blistering, hypopigmentation (lightening of the area), hyperpigmentation (darkening of the area), swelling, allergic reactions, bruising, scarring, pin-point bleeding, pimple-like bumps, dry skin, tingling, and other similar side effects and/or reactions. I understand these risks also include, but are not limited to, the following:

1. Scarring: This treatment can create bruising and a moderate burn or blister to the skin. Depending on treatment received, more serious side effects may include, skin indentations or subcutaneous fat loss, and open sores that lead to infection.

2. Pigmentation: The treated area may become either lighter (hypo-pigmented) or darker (hyper-pigmented) in color. This is rare and is usually just temporary, however may become permanent.

3. Infection: Although infection following this treatment is unusual, bacterial, fungal, and viral infections can occur. Herpes Simplex virus infections around the mouth can occur following a treatment, even if there is no past history of Herpes Simplex virus infections in the mouth area. Clients with a history of Herpes Simplex virus in the treated area are encouraged to seek preventative therapy. Should any type of skin infection occur, additional treatment, including antibiotics, may be necessary.

4. Skin tissue pathology: Only clearly benign pigmented lesions can be treated. A doctor's clearance should be obtained in the case of this type of treatment. Treatment directed at abnormal lesions can cause malignant cells to develop and laboratory examination of the tissue specimen may not be possible.

5. Allergic reactions: Due to skin surface disruption, irritation and histamine reactions may occur resulting in itching, dermatitis, or other forms of sensitivity. In rare cases, local allergies to topical preparations have been reported.

I certify that this consent has been fully explained to me, that I have read the above paragraphs, and that I elect to the advanced esthetic procedure(s) indicated above.

I understand the various risks associated with the procedure(s) and the importance of properly following pre-procedure and aftercare instructions to minimize those risks.

CLIENT / GUARDIAN SIGNATURE: DATE:

TECHNICIAN SIGNATURE: DATE:

NOTICE: Occasionally, unforeseen problems may occur, and your appointment will need to be rescheduled. We will make every effort to notify you prior to your arrival to the office.
Please be understanding if we cause you any inconvenience.