CLIENT CONSULTATION AND RELEASE FORM

Please read carefully, complete, sign and date this form prior to your treatment.

Name: _____ Phone: (_____) _____

Address: _____

City: _____ State: _____ Zip: _____

☐ HYDRAFACIAL ☐ MICRODERMABRASION ☐ BLUE LIGHT THERAPY ☐ RED LIGHT THERAPY ☐ VACUUM THERAPY

SECTION 1: MEDICAL INFORMATION

- Do any of the following conditions relate to you?

YES	NO	
☐	☐	Accutane or other similar medication
☐	☐	Allergies
☐	☐	Autoimmune disease, HIV, lupus, hepatitis
☐	☐	Blood thinners – Heparin, Coumadin, Warfarin, etc.
☐	☐	Breast feeding, pregnancy
☐	☐	Cancer or post-cancer treatments
☐	☐	Cardiovascular problems
☐	☐	Cold sores or fever blisters without pre-medication
☐	☐	Cortisone or steroid injections
☐	☐	Cosmetic injections, fillers or implants, (i.e. Botox®, collagen)
☐	☐	Eczema, psoriasis
☐	☐	Enlarged or painful glands
☐	☐	Epilepsy
☐	☐	Facial waxing services w/in 7-14 days
☐	☐	Heart ailment
☐	☐	Hypertension/high blood pressure
☐	☐	Inflammatory conditions
☐	☐	Irregular, pigmented moles, warts or growths, unidentified facial growth or mark
☐	☐	Keloids, pigmented scars, icepick scars, new scar tissue
☐	☐	Laser procedures, chemical peels, dermabrasion, microdermabrasion
☐	☐	Light sensitive medication
☐	☐	Loose, thin, aged skin
☐	☐	Lymphatic disorder, inflammation of lymph vessels, lymphedema
☐	☐	Medication:
☐	☐	Pacemaker or metal implants
☐	☐	Phlebitis, varicose veins
☐	☐	Recent accident or serious injury
☐	☐	Recent surgical or dental procedure
☐	☐	Rosacea, telangiectasia/couperose
☐	☐	Retin-A, Retinol
☐	☐	Skin abrasions or lesions
☐	☐	Stage III or IV acne
☐	☐	Skin-lightening or bleaching agent

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☐	☐	Sunburn
☐	☐	Swollen or infected tonsils
☐	☐	Thyroid conditions
☐	☐	Type I diabetic
☐	☐	Under medical care for an existing or suspected condition or disease
☐	☐	Viral infection, influenza
☐	☐	Other contraindication at discretion of skincare technician or medical practitioner:

- My interest in skincare treatment is primarily for (i.e. skin rejuvenation, acne, hyperpigmentation, scarring, etc.)

  _____

  _____

- Specify your areas of concern (i.e. eyes, forehead, etc.)

  _____

  _____

SECTION 2: CLIENT CONSENT FORM

(Initial each acknowledgement line below)

1. I acknowledge that I have not used Accutane or any medication for the same purpose during the last 12 months. _____*(initial here)*

2. I acknowledge that if I have ever had a cold sore or fever blisters, I should consult with my physician or pharmacist for a pre-use medication to help avoid a possible breakout. That medication should be used each day for two days before, same day, and two days after any aggressive facial exfoliation treatment. _____*(initial here)*

3. I acknowledge that there is no guarantee that dark discoloration of skin will be reduced or fade. Pigmentation may improve or darken with successive treatments. I acknowledge the need for proper skin care home regimen. _____*(initial here)*

4. I acknowledge that my skin might experience temporary irritation, tightness, redness or slight swelling which usually dissipates within 72 hours depending on skin sensitivity. _____*(initial here)*

5. I acknowledge that if I fail to use a minimal sunscreen (SPF 15), I am more susceptible to sunburn, skin damage & hyperpigmentation. _____*(initial here)*

6. I acknowledge that this treatment is strictly an elective cosmetic procedure and that no medical claims have been expressed or implied. _____*(initial here)*

7. I acknowledge that I should avoid use of glycolic products for 2-4 weeks following the treatment. _____*(initial here)*

8. I acknowledge that I should avoid use of Retin-A type products for a period of time recommended by my ☐ **medical** or ☐ **skincare** professional during and following the treatment. _____*(initial here)*