



CLIENT INFORMATION AND SKIN CARE PROFILE

THIS INFORMATION IS COMPLETELY CONFIDENTIAL AND WILL BE USED FOR THIS ANALYSIS ONLY

Date ____/____/____

Client Name _____ Age _____ Birthday ____/____/____

Address _____ City _____ State _____ Zip _____

Cell _____ Home _____ Email _____

Occupation _____ Employer _____

Preferred Appointment Day: Mon. Tues. Wed. Thurs. Fri. Sat. Time: Morning Mid-Day Afternoon

Confirmation Preference (note: we default to email if one is not chosen): Text Cell Phone Home Phone Email

Referred By: _____

Allergies: _____

Current Medications: _____

Other/Explain: _____

LIFESTYLE

Daily Consumption: Water _____ oz's Coffee _____ cups Soft Drinks _____ oz's Alcohol? Yes No

PERSONAL SKIN CARE

Soap Cleanser Toner Moisturizer Masque Scrub _____

FEMALE CLIENTS ONLY

Are you currently taking oral contraception? Yes No

Are you currently pregnant or trying to become pregnant? Yes No

MALE CLIENTS ONLY

Shaving System? Wet Dry Ingrown Hairs? Yes No

Medical

Health Problems: Cancer Diabetes Thyroid Hysterectomy Hormone Imbalance

1	Yes	No	Are you under a physician's care for any medical condition at this time?	23	Yes	No	Have you ever had cold sores?
2	Yes	No	Are you pregnant or nursing?	24	Yes	No	Do you have any type of herpes?
3	Yes	No	Do you have eczema?	25	Yes	No	Do you wear contact lenses?
4	Yes	No	Do you have psoriasis?	26	Yes	No	Do you wear glasses?
5	Yes	No	Do you have hemophilia?	27	Yes	No	Do you have glaucoma?
6	Yes	No	Do you have acne?	28	Yes	No	Do you have dry eye syndrome?
7	Yes	No	Do you have skin cancer?	29	Yes	No	Do you have blocked tear ducts?
8	Yes	No	Do you have vitiligo?	30	Yes	No	Do you have allergies to latex?
9	Yes	No	Do you have rosacea?	31	Yes	No	Do you bruise easily?
10	Yes	No	Do you have dermatitis?	32	Yes	No	Do you have any problems healing from minor wounds?
11	Yes	No	Do you hyperpigment when you scar?	33	Yes	No	Do you tend to develop keloid or hypertrophy scars?
12	Yes	No	Do you hypopigment when you scar?	34	Yes	No	Do you have a tendency to faint or become dizzy?
13	Yes	No	Have you had plastic surgery?	35	Yes	No	Are you undergoing radiation or chemo-therapy treatment?
14	Yes	No	Are you contemplating plastic surgery?	36	Yes	No	Are you sensitive to petroleum based products?
15	Yes	No	Do you have high blood pressure?	37	Yes	No	Are you now, or have you ever been on the acne treatment Accutane?
16	Yes	No	Do you have low blood pressure?	38	Yes	No	Are you under treatment for depression?
17	Yes	No	Do you have asthma?	39	Yes	No	Do you take prescription drugs?
18	Yes	No	Do you have any type of heart disease?	40	Yes	No	Do you intentionally tan- direct sun or tanning bed?
19	Yes	No	Do you wear a pace maker?	41	Yes	No	If you tan, do you burn easily?
20	Yes	No	Do you have any medical implants?	42	Yes	No	Do you have a history of stroke or heart attack?
21	Yes	No	Do you have diabetes or any auto-immune disorders?	43	Yes	No	Do you take any herbal supplements?
22	Yes	No	Do you have any seizure related condition?	44	Yes	No	Do you have any problems being anesthetized for dental procedures?

Consent Form

Read this consent form thoroughly and initial each section as needed. Discuss any questions with your skin care professional before you initial. Your signature and date at the bottom constitutes giving your consent to the initialed treatments and procedures.

I _____ give my consent for the following procedure(s):

Skin Care Treatment consent: _____

I have notified the skin care professional of any previous or current skin disorders or blemishes. I understand the possible complications and consent to the following skin care procedure(s).

Waxing consent: _____

I have advised my waxing specialist of any of the following: cuts or abrasions, inflammation, open wounds, suspicious growths, active herpes, hemophilia, use of Accutane, use of Retin-A, use of AHA's, recent infections, diabetes, or phlebitis.

Have you ever had any adverse reactions to waxing? _____

I understand that following the waxing procedure, I should: apply a sunblock with an SPF of at least 15, avoid the use of a loofah or other abrasives to the waxed area, avoid saunas, steam rooms, Jacuzzis, or other heat sources, and avoid application of Retin-A or an AHA product for 48 hours. Please note that you may be more sensitive to the waxing procedure if you are premenstrual or taking antibiotics.

Lash Enhancements consent: _____

I understand that the glue has a 2 second dry time and is best used in dryer climates. The adhesive does have more fumes that can cause some irritation at time of application. It does not contain formaldehyde or latex, and is very compatible for people with sensitive skin. The adhesion time has a 5-6 week bonding time. The longevity is best if after care instructions are followed to avoid losing your lashes. If you choose to maintain the lash extensions, you must come in every 3 weeks to maintain care or have the technician properly remove them.

Chemical Peel consent: _____

PRE-TREATMENT

One Week Prior

- Avoid electrolysis, waxing, depilatory creams and laser hair removal.
- Cease using any exfoliating products that may be drying or irritating, such as salicylic acid, alpha hydroxy acid and glycolic acid.

Three Days Prior

Cease using:

- Retin-A, Renova®, Differin® (Adapalene 0.1%).
- Any products containing Retinol AHA or BHA, or Benzoyl Peroxide.

Patients who have had a medical/cosmetic facial treatment or procedure such as: BOTOX®, facial, facial hair removal, injectable filler, laser treatment, microdermabrasion, etc., are advised to wait until skin sensitivity subsides before receiving Renaissance 2 Peel.

Use of any of these products or procedures may increase sensitivity and patient may have stronger reaction.

Dermaplaning consent: _____

I understand there are contraindications to this treatment, including but not limited to, diabetes, cancer, active acne, bleeding disorders and the inability for blood to coagulate following injury. Certain medications including blood thinners such as Coumadin, Warfarin, Heparin, Plavix, and/or Aspirin, and Accutane are contraindicated for this treatment due to the possibility of excessive bleeding from a nick or cut. I certify that I am not taking any of the above medications or experiencing any of the above conditions. I understand this treatment involves the use of the sterile, surgical blade to remove dead skin cells and villous hair. As with the use of any sharp instrument, there is the possibility of nicks or cuts. While every precaution is taken I understand the risks and consent to the treatment.

I have completed the client medical form accurately: _____

I have completed the skin type test: _____

- I understand that there are no guaranteed results from any treatments. Many variables such as age, sun damage, ongoing sun exposure, smoking, excessive alcohol intake, climate, diet, water intake, skin thickness, and sensitivity can affect the results of all treatments. I have been candid in revealing any condition that could prohibit any treatment such as cold sores, pregnancy, and use of hormones (birth control or HRT), recent facial surgery or laser resurfacing, recent use of Retin-A, or use of Accutane within the last 6 months. Any immune system diseases including but not limited to Lupus, HIV, or diabetes can affect the healing time of certain procedures. Regardless of precautions taken, I acknowledge the possibility of an adverse reaction to treatments and accept sole responsibility for any medical care that may become necessary. I will immediately notify the doctor, nurse, or esthetician performing the treatment of any adverse reactions. I will not scratch, pick, pull at, or abrade the treated skin. I understand that direct sun exposure and use of a tanning booth is prohibited during dermaplaning and chemical peel treatments for 14 days post peel, or the amount of time discussed by the aesthetician. I will comply with the mandatory use of a minimum SPF 15 sun protection daily. I have not received any other peels or exfoliation treatments of any kind within 14 days of this treatment. I understand that to achieve maximum results the recommended home care routine must be followed. I understand that if I alter the routine or use products not recommended by the skin care professional the results could be altered or inhibited. I also understand that it may take several treatments to obtain the desired results. I understand that the following side effects or complications can occur: discomfort, redness and swelling, hypopigmentation, itching or irritation, skin peeling or flaking up to 14 days after the procedure, infection, scarring, hyperpigmentation, and/or acne breakouts. I understand the goals of the treatment about to be received as well as the limitations and possible complications. The technician has provided the information and has answered all my questions concerning this procedure. After treatment patient can Call office immediately if you experience other adverse reactions. I clearly understand the above information.

Cancellation Policy

We understand that sometimes life happens, we do request a 24 hour notice of cancellation if you must cancel your appointment so that we have time to schedule another client as we have reserved this time for you. No Shows will be charged 100% for the service reserved. A minimum of \$50 will be charged at the discretion of management. Last minute cancellations will be charged 50 % for the service reserved. If the service time can be filled by another client, you will not be charged. All sales are final no refund policy funds may be transferred.

Client Signature _____ **Date** _____

Parent/Guardian Signature* _____ **Date** _____

*for clients under the age of 18

Physician/Technician Signature _____ **Date** _____

Fitzpatrick Skin Test

Skin Type Evaluation

Score	0	1	2	3	4	Your Score
Your natural eye color?	Light: Blue, Gray, or Green	Med: Blue, Gray, or Green	Blue	Dark Brown	Brownish Black	
Natural color of your hair?	Sandy or Red	Blonde	Chestnut or Dark Blonde	Dark Brown	Black	
Color of your <i>non-exposed</i> skin?	Reddish	Very Pale	Pale with a Beige Tint	Light Brown	Dark Brown	
Do you have freckles on <i>non-exposed</i> areas?	Many	Several	Few	Incidental	None	

Genetic Disposition Score _____

Score	0	1	2	3	4	Your Score
What happens if you stay too long in the sun?	Painful redness, blistering, peeling	Blistering, followed by peeling	Burns, sometimes followed by peeling	Rarely burns	Never burns	
To what degree do you turn brown?	Hardly or not at all	Light color tan	Reasonable tan	Tan very easily	Turn dark very quickly	
Do you turn brown within several hours after the sun exposure?	Never	Seldom	Sometimes	Often	Always	
How does your face react to the sun?	Very sensitive	Sensitive	Normal	Very Resistant	Never had a problem	

Sun Reaction Score _____

Score	0	1	2	3	4	Your Score
What happens if you stay too long in the sun?	Painful redness, blistering, peeling	Blistering, followed by peeling	Burns, sometimes followed by peeling	Rarely burns	Never burns	
To what degree do you turn brown?	Hardly or not at all	Light color tan	Reasonable tan	Tan very easily	Turn dark very quickly	

Tanning Habits Score _____

Total Score _____

If your total score is:	Then your Fitzpatrick skin type is:
0-7	I
8-16	II
17-24	III
25-30	IV
Over 30	V-VI