# HYDROPEPTIDE® CLIENT INTAKE AND CONSENT FORM

Thank you for your interest in the HydroPeptide Skin Care Collection. Please fill in the requested information to assist your skin care professional in analyzing your skin and addressing your concerns. This information will also be used to ensure that you receive the best care possible by making your skin care professional aware of contraindications or medical conditions so that they can choose the targeted treatment best suited to your skin. You may be asked to update this form prior to each visit in order to track changes and progress and ensure that you achieve your skin care goals.

## BASIC INFORMATION

FULL NAME ______________________

EMAIL ______________________

DATE OF BIRTH ____________

ADDRESS ______________________

CITY ______________ STATE ____________

ZIP CODE ____________ CELL ____________

HOME PHONE ______________________

OCCUPATION ______________________

DO YOU DRINK ALCOHOL? ☐ Y ☐ N HOW OFTEN? ____________

DO YOU LIVE WITH A SMOKER? ☐ Y ☐ N

DO YOU SMOKE? ☐ Y ☐ N HOW OFTEN? ____________

## MEDICAL INFORMATION

DO YOU CURRENTLY HAVE OR BEEN TREATED FOR:

☐ ACNE ☐ DEPRESSION ☐ SKIN DISEASE ☐ HIGH BLOOD PRESSURE

☐ COLD SORES ☐ DIABETES ☐ CANCER ☐ ROSACEA (REDNESS)

HAVE YOU USED ANY OF THE FOLLOWING WITHIN THE PAST 72 HOURS?

☐ RETIN-A ☐ BENZOYL PEROXIDE ☐ FACIAL WAXING ☐ OTC ACNE TREATMENTS

☐ RETINOL ☐ CHEMICAL PEEL ☐ LASER TREATMENT IN THE PAST 4 WEEKS?

HAVE YOU USED ACCUTANE WITH THE PAST YEAR? ☐ Y ☐ N

LIST ANY RECENT RESURFACING PROCEDURES (INCLUDING MICRODERMABRASION) OR SURGERIES (INCLUDING COSMETIC)

______________________

______________________

LIST ALL MEDICATIONS YOU ARE TAKING ______________________

______________________

LIST ALL KNOWN ALLERGIES ______________________

______________________

LIST ALL HEALTH CONCERNS ______________________

______________________

ARE YOU PREGNANT OR NURSING? ☐ Y ☐ N ARE YOU ALLERGIC TO ASPIRIN? ☐ Y ☐ N

## SKIN CARE INFORMATION

WHAT IS YOUR CURRENT LEVEL OF STRESS?

LOW ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 HIGH

WHAT IS YOUR NORMAL LEVEL OF STRESS?

LOW ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 HIGH

HOW DO YOU FEEL ABOUT THE QUALITY OF YOUR SKIN?

BAD ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 GOOD

DO YOU WEAR SUNSCREEN? ☐ Y ☐ N

## SKIN CARE INFORMATION *CONTINUED*

PLEASE LIST ANY VITAMINS OR SUPPLEMENTS YOU MAY BE TAKING ______________________________

______________________________

HOW OFTEN DO YOU EXERCISE? DESCRIBE ______________________________

______________________________

HOW MUCH WATER DO YOU DRINK DAILY? __________ WHEN WAS YOUR LAST SUNBURN? __________

WHEN IN THE SUN, DO YOU BURN
- ☐ ALWAYS
- ☐ USUALLY
- ☐ SOMETIMES
- ☐ RARELY
- ☐ VERY RARELY
- ☐ NEVER

DESCRIBE YOUR SKIN TYPE?
- ☐ NORMAL
- ☐ SENSITIVE
- ☐ DRY / DEHYDRATED
- ☐ NOT SURE
- ☐ OILY
- ☐ ROSACEA
- ☐ ACNE / ACNE PRONE

WHICH SKIN CONDITIONS ARE YOU MOST CONCERNED ABOUT?
- ☐ WRINKLES
- ☐ DARK SPOTS
- ☐ DULLNESS
- ☐ OILINESS
- ☐ ACNE
- ☐ ACNE SCARRING
- ☐ REDNESS
- ☐ DRY / ROUGH

OTHER ______________________________

WHAT ARE YOU SPECIFICALLY WORRIED ABOUT TODAY? ______________________________

______________________________

WHAT IS YOUR CURRENT SKIN CARE ROUTINE? PLEASE LIST PRODUCT NAMES AND REGIMEN

______________________________

WHAT DO YOU LIKE ABOUT YOUR SKIN? ______________________________

______________________________

WHAT DON'T YOU LIKE ABOUT YOUR SKIN? ______________________________

______________________________

## CLIENT CONSENT

Prior to receiving treatment, I have been candid in revealing any condition that may be a contraindication to this treatment, such as: pregnancy or lactating (if so, consult with your physician prior to treatment and avoid products containing salyclylic acid). Recent facial surgery, allergies, tendency to cold sores/fever blisters, use of topical and/or oral prescription medications such as: Tretinoin, Retin- A, Isotretinoin, Accutane, Differin, Tazorac, Avage, EpiDuo or Ziana.

_______ I UNDERSTAND THAT THERE MAY BE SOME SLIGHT TINGLING OR PIN-PRICKING SENSATION.

_______ I UNDERSTAND THERE ARE NO GUARANTEES AS TO THE RESULTS OF THIS TREATMENT, DUE TO MANY VARIABLES SUCH AS: AGE, CONDITION OF SKIN, SUN DAMAGE, SMOKING, CLIMATE, ETC.

_______ I UNDERSTAND I MAY NOT ACTUALLY PEEL AND THAT SUCH CASES DEPEND ON THE INDIVIDUAL. I UNDERSTAND THAT THE ABSENCE OF PEELING DOES NOT CORRELATE TO THE AMOUNT OF IMPROVEMENT.

_______ I UNDERSTAND THIS IS A COSMETIC TREATMENT AND THAT NO MEDICAL CLAIMS ARE EXPRESSED OR IMPLIED.

_______ I UNDERSTAND TO ACHIEVE MAXIMUM RESULTS I MAY NEED SEVERAL TREATMENTS AND REGULAR USE OF HYDROPEPTIDE PRODUCTS AT HOME.

_______ I UNDERSTAND THOUGH COMPLICATIONS ARE RARE, SOMETIMES THEY MAY OCCUR. IN THE EVENT OF ANY COMPLICATION I WILL IMMEDIATELY CONTACT THE CLINICIAN WHO PERFORMED THE TREATMENT.

_______ I UNDERSTAND THAT EXTENDED DIRECT SUN EXPOSURE IS PROHIBITED WHILE I AM UNDERGOING TREATMENTS, AND THE DAILY USE OF SUNSCREEN PROTECTION WITH A MINIMUM OF SPF 30 IS MANDATORY.

_______ I UNDERSTAND THAT I SHOULD FOLLOW MY CLINICIAN'S RECOMMENDATIONS FOR POST-PROCEDURE SKIN CARE TO MINIMIZE SIDE EFFECTS AND TO MAXIMIZE RESULTS.

I hereby agree to all of the above and agree to have this treatment performed on me.

SIGNATURE ______________________________ DATE __________

CLINICIAN ______________________________ WITNESS __________