# ZK Skin Essentials

## Client Consent Form - Microcurrent

Name:_______________________________________________________________
Address:__________________________________City:________State:______ Zip:________
Home/Cell Phone: ___________________________Email: ______________________________
How should we contact you? Home/Cell Phone:________ Email:_______
When is best time to contact you? Morning:_____ Daytime:______Evening:______
Emergency Contact Name: ______________________________Relationship:_______________
Phone:_______________________

**Health History**

Please list any  allergies you have:___________________________________________________
Please list all current medications you are taking (including oral and topical prescriptions, over-the counter herbs, vitamins and supplements):________________________________________

**These questions are relevant to your skin health and may be contraindications for treatments. Please answer throughly.**

| Questions | Yes | No | Details if applicable | Adverse reactions if applicable |
|---|---|---|---|---|
| Are you pregnant? | | | | |
| Do you wear contacts or glasses? | | | | |
| Do you have any metal implants, including plates, screws, pins? | | | | |
| Do you have braces, metal fillings or other dental implants? | | | | |
| Do you have any metal piercings? | | | | |
| Do you have a pacemaker? | | | | |
| Do you have any heart problems? | | | | |
| Do you have high/low blood pressure? | | | | |
| Do you currently have cold or flu? | | | | |

| Questions | Yes | No | Details if applicable | Adverse reactions if applicable |
|---|---|---|---|---|
| Do you have an autoimmune disorder or connective tissue disease? | | | | |
| Have you had any previous facial treatments? | | | | |
| Do you use Retin-A, Accutane or any other prescription topical Vitamin A derivative? | | | | |
| Have you ever had a Botox, Juvederm, or any other injectable? | | | | |

**Have you ever had any of these conditions? (please circle)**

| Acne rosacea | Bell's palsy | Cold sores | Diabetes |
|---|---|---|---|
| Embolism | Epilepsy | Light sensitivity | Melanoma |
| Migraines | Open wounds | Phlebitis | Recent scar tissue |
| Sensitive skin | Skin inflammation/ disorders | Stroke/TIA | Thrombosis |
| Thyroid conditions | Varicose veins | | |

Any other health condition not listed:_______________________________________________

_________________________________________________________________________

Is there anything else we should know?______________________________________________

_________________________________________________________________________

Although every precaution will be taken to ensure your safety and wellbeing before, during and after your micro current treatment , please be aware of the following information and possible risks. Please initial:

______ I understand there are certain contraindications that would preclude me form receiving micro current treatments, including autoimmune disorders, diabetes, embolism, epilepsy, melanoma, metal implants including plates/pins/screws, open wounds, pacemaker use, phlebitis, pregnancy, thrombosis, and varicose veins.

______ I understand that the use of Botox, Juvederm, Restylane, and any other injectable just be disclosed prior to treatment.

______ I understand that micro current treatments involve conducting mild electrical current through the body, and that this brings some inherent risk.

______ I understand that reactions are rear, but may include nausea, dizziness, weakness, and possible skin reactions including redness and/or other irritations.

_____ I understand that some clients report slight tingling sensations, flashing of the optic nerve, and/or a metallic taste in the mouth during the procedure.
_____ I understand that while the goal of tis treatment is to improve the viability of the skin, no specific guarantees of the result can or have been made.
_____ I understand that it is imperative to me health tat I disclose all of the information requested in the Client Profile/Health History.
_____ I have cited all conditions and circumstances regarding my health history, medications being taken, and any past reactions to products or medications.
_____ I understand that additional; conditions could occur or be discovered during the procedure which could affect my ability to tolerate the procedure.
_____ I consent to "before and after" photographs for the purpose of documentation, potential advertising and promotional purposes.

I understand that if I have any concerns, I will address these with my skin care specialist. I give permission to my therapist to perform the micro current procedure we have discussed, and will hold him/her and his/her staff harmless and nameless from any liability that may result from this treatment. I have accurately answered the questions above, including all known allergies, prescription drugs, conditions, or products I am currently ingesting or using topically. I understand my skin care specialist will take every precaution to minimize or eliminate negative reactions as much as possible. In the event I may have additional questions or concerns regarding my treatment, I will consult the skin care specialist immediately. I agree that this constitutes full disclosure, and it supersedes any previous verbal or written disclosures. I certify that I have read, and fully understand the above paragraphs and that I have sufficient opportunity for discussion to have any questions answered. I understand the procedure and accept the risks. I do not hold the skin care specialist, whose signature appears below, responsible for nay of my conditions that were present, but not disclosed at the time of this procedure, which may be affected by the treatment performed today.

Client Name (printed)_______________________________________________
Client Name (signature)______________________________________________
Skin care specialist _________________________________________________

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