"YES YOU ARE"

CLIENT PROFILE & TREATMENT INFORMATION

Name	**Date**
Address	**Birthday (MM/DD/YY)**
Phone# _____cell ____home ____work **Ok to leave a message? Yes / No**	**Email**
Occupation	**Emergency contact name & #**

General query questions		
1	What product are you using to cleanse your face? ie. soap or type of face wash	
2	Cleanse both morning and evening	Yes / No
3	Do you exfoliate or do other at home treatments? ie. masks, whitening, other abrasive treatments	
4	Do you use moisturizer daily? If so, brand/type	
5	Do you use a SPF daily? If so, brand/strength	
6	Do you use any serums? Morning / evening If so, type(s)	
7	When was your last facial? Or at home type treatments? What?	
8	Are you claustrophobic (fear of small spaces)?	
9	In last 6-12 months, injections of Botox or fillers?	
10	Any other treatments? ie. chemical peels, micro-dermabrasion or needling, dermaplaning, laser or IPL? when?	
11	Have you had any reactions to any products or treatments received prior?	
12	Do you have any allergies?	
13	Do you follow a special or preferred diet?	

14	# of glasses of water do you drink a day?	
15	Do you take powders or fish oils? Ie. protein, collagen, omega3's, fish oil, D3	
16	# Coffee/Tea & Carbonated Drinks a day, specify	
17	Do you have any pigmented areas or moles? What and where?	
18	Any health issues? Diabetes, heart or thyroid issues, etc.	
19	Are you taking any prescription medications?	
20	Are you taking any type of over counter pain medication? Ie. Aspirin, Advil, Excedrin etc. Or supplements ie. St. John's Wort, Garlic capsules, etc.	
21	Do you currently have acne, black/white heads? Have you ever used or are your using acne creams or medications? Ie. Proactive, Accutane, etc.	
22	Do you get skin rashes or have broken capillaries? What and where?	
23	Any surgeries? When?	
24	Do you have any type of metal implants / plates?	
25	Any neck or back issues?	
26	Tested positive for: Herpes, HIV, AIDS, Hepatitis	
27	Are you nursing or pregnant, regular cycle?	
28	What are your main skin concerns?	
29	What service are you receiving today? Have you had it before? Do you understand the treatment?	
30	Are you open to future treatment(s) to achieve the most beautiful you? Are there other treatments you wish to discuss?	

In order to enable I AM Beautiful Rx ("IAMBRX") and/or referred professionals to provide the best, safest and most effective treatment plan for me, I have answered all the questions above to the best of my knowledge to enable me to get optimal results. My privacy will always be respected, as such, all the information provided herein will remain strictly confidential unless I have authorized otherwise. These questions will be reviewed to address any questions or concerns and to update any information for the current and future treatments.

See "TREATMENT PLAN" CHART Appendix "A"

Agree & consent (initial)	
	I understand that redness, sensitivity, peeling or other reactions may occur from skin being treated. If I experience any discomfort during the session, I will immediately inform the esthetician so that the products and/or technique may be adjusted to my level of comfort.
	I understand that following my consented and authorized treatment, I will be advised of post-care protocol and I will follow the recommendations given/discussed and follow proper use of products. It is important that I get the optimal result from the valued treatment(s) received.
	I understand any products or treatments not discussed/approved that is applied or given by myself or others immediately after, may cause an undesired outcome which will be unrelated to the treatment by “IAMBX”.
	I further understand that estheticians are not qualified to diagnose, prescribe or treat any disease or illness found or noted during a treatment/assessment and is not be a replacement for any medical treatment that may be required.
	I consent to the desired “Treatment Plan(s)” determined by the dated assessment and information provided. I release “IAMBX” and/or skin care professional from liability and assume full responsibility thereof.
	I agree to before and after for promotional/public social media use OR ______ With eyes blacked out is OK.
	I agree to before and/or after photos of all treatments for office or referral use only.
	I agree to promotional emails and offers to be sent to the email address provided.
	I agree to treat IAMBRX staff and professionals in a respectful manner and I in return. Any disputes will be handled in a professional and confidential manner where resolution can be found.
	I have answered all the questions truthfully to the best of my knowledge.
	I have not traveled outside of Canada in the last 30 days.
	I have not tested positive for a Covid virus or been in contact with anyone who has tested positive to the best of my knowledge in last 30 days.
	I currently do not have Covid symptoms ie. Fever, loss of smell or taste, sore throat, cough, etc.

Client Signature_______________________________________ Date_______________________________

Print Name: ____

Witness Signature_____________________________________ Date_______________________________

Print Name: ____

“Putting your best face forward”