Electrolysis Center
8077 Florence Ave, Suite 203A
Downey, CA 90240
(562) 343-6749

Electrolysis Center
9649 Lakewood Blvd
Downey, CA 90240
(562) 417-7449

Client Health History Assessment

Client Number:
electrolysis office use only

Primary Information

Today's Date: MM / DD / YYYY Date of Birth: MM / DD / YYYY

Legal First Name: _____ Middle Initial: _____ Legal Last Name: _____

Preferred Name: _____ Gender Identified as: _____

Street Address: _____ City: _____ State: _____ Zipcode: _____

Phone: **home / mobile** (____) _____ Email: _____

How can we contact you for appointment changes & reminders? {circle all that appply} Call / Text / Email

Emergency Contact Name: _____ Phone: (____) _____ Relationship: _____

Hair Removal Information

Areas you are considering for treatment? {circle all that apply}

Head: Lip / Mustache Chin Beard Eyebrows Unibrow Ears {outside} Sideburns Hairline Neck

Body: Armpits Breast / Chest Navel / Happy Trail Bikini / Groin Anus Penis Shaft Upper Back Lower Back

Limbs: Shoulders Upper Arms Lower Arms Hands Fingers Outer Thighs Inner Thighs Lower Legs Feet Toes

Other: _____

Hair Removal Methods

What hair removal methods do you most frequently use? {circle all that apply}

	Waxing	Sugaring	Tweezing	Creams	Laser	Threading	Other:
Frequency	____ times	____ times	____ times	____ times	____ times	____ times	_____ times
per	day/wk/mth	day/wk/mth	day/wk/mth	day/wk/mth	day/wk/mth	day/wk/mth	per day/wk/mth

Have you ever had electrolysis before? yes / no Electrologist's name: _____ location: _____

Date of last treatment: _____ Body part(s) treated: _____

Total # of treatments: _____ Modality: {circle all that apply} Thermolysis Blend Galvanic Not Sure

Skin reactions to any previous hair removal methods? {circle all that apply}

None Redness Swelling Ingrown Hair Infection Bumps/Pimples Other: _____

Other Information

How did you hear about us? Website Facebook Instagram Pinterest Google Referral ... who? _____

Other: _____

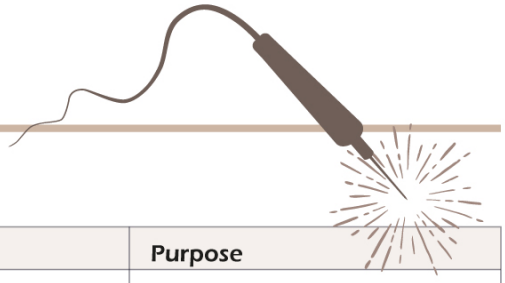
Media Release

Do we have permission to document your hair removal process through your story, pictures and or videos and use them in our company's print and/or digital publications? **Photographs:** yes / no **Videos:** yes / no **Initials:** _____

Client Comments & Questions: _____

Continue to other side →

Client Health History Assessment



Health Information

List All Medications & Vitamins You are Currently Taking:

Name	Purpose	Name	Purpose

List All Allergies:

Name	Comments	Name	Comments

Health Conditions Present or Past: {circle all that apply}

Acne Body Piercings Beathing Problems Cancer Cardiovascular Disease Clotting Issues Cold Sores COPD Diabetes Dizziness / Fainting Heart Attack Healing Issues Hepatitus Herpes High Blood Pressure HIV Infertility Metal Implants Keloids Kidney Disease Pacemaker Piercings PCOS TB Thyroid Disease Skin Tags Stroke Warts

Other: _____

Dermabrasion: yes / no **Last application:** MM / DD / YYYY

Are you pregnant: yes / no **Do you get your period:** yes / no **If yes, is it regular:** yes / no

Have you traveled outside of the country in the last 30 days: yes / no **Where:** _____

Have you had any major surgeries? yes / no **Specify:** _____

Are you preparring for sex reassignment surgery? yes / no **Planned Date of Surgery:** MM / DD / YYYY

Physician's Name: _____ **Phone:** ( ) _____

Physician's Location: _____ **May we contact to discuss your treatment plan:** yes / no

Client Acknowledgement of Information

I understand health history information is important to my Electrologist in order to provide me with safe and effective electrology treatments. I acknowledge all information given by me is accurate to the best of my knowledge, and I agree to update my health history assessment whenever there are changes. _____ Initials

I understand that a series of treatments is necessary to achieve permanent hair removal and my progress will be impacted by my personal hair growth rate, the science of electrology, and my individual physiological factors. _____ Initials

I have been advised of the post-treatment care, the healing process and the possible risks related to treatment. I agree to follow all aftercare instructions and to notify my Electrologist of any concerns or difficulty in healing. _____ Initials

I understand my electrologist has the right to refuse treatment if it is not beneficial to my health or skincare due to known or unknown health conditions I may have. _____ Initials

Client Name: _____ Signature: _____ Date: MM / DD / YYYY

If under 18, parent/guardian must sign.

Parent's Name: _____ Parent's Signature: _____ Date: MM / DD / YYYY

ELECTROLYSIS CENTER

OFFICE POLICY

Payment

Payment is expected at the time of services. You will be billed for the appointment time that was scheduled. We accept all major credit cards, debit cards, including FSA, HSA payments, cash, Venmo & Zelle. There is a $3 surcharge on all credit, debit and FSA & HAS cards.

Cancellations

We request that you give at least 24 hour notice for 1 hour or shorter appointment and at least 48 hour notice for over 1 hour appointments. This time is reserved exclusively for you and we would like to be able to fill it if you cannot make it to your appointment. Appointments NOT cancelled at least 24/48 hour notice a minimum of $40 or 50% of your appointment fee (whichever is higher) will be charged to your credit card on file and/or billed on your next appointment.

If an emergency happens and you have to cancel less than 24/48 hours, we understand. If it becomes a regular problem or if you do not call or show up for your appointment more than twice in a one-year period, you will have to pre-pay to get an appointment and forfeit the payment if you do not show up for your appointment without adequate notice.

All Saturday and Sunday appointments will be charged a missed appointment fee if you do not show up or cancel with less than 24/48 hour notice.*

If you have symptoms of COVID-19 or if you have been in close contact with someone that is positive, please reschedule your appointment as soon as possible. COVID related cancellations are exempt from our policies as long as you do not abuse them.

*Insurance patients with two (2) or more missed/no show appointments will be removed from our services.

Late Arrivals

Each time slot is reserved for the person in it. If you arrive late, we will try to accommodate your full appointment, however, if we cannot do so your time will be shortened accordingly. Since the missed time is time that we could not allocate to another person, we reserve the right to charge the price of your full appointment.

I have read the above information and understand the above office policy.

_____ _____ _____

Name Signature Date