

# *Bare Essentials*

## **Laser Hair Removal Treatment**

Client Intake Form

Please complete the form below to the best of your ability. Forms can be submitted in person at the time of your appointment or sent via e-mail to: [support@bareessentialsbysunni.com](mailto:support@bareessentialsbysunni.com)

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**Legal Name:**

**Date of Birth:**

**E-Mail Address:**

**Pronouns:**

**Phone Number:**

**How did you hear about Indulgence Studio?**

**Areas you would like treated:**

**Laser Hair Removal Screening Form Consult Date:**

**What hair removal methods do you currently use?**

Waxing      Shaving      Sugaring      Creams      Tweezing      Electrolysis

**When was your last treatment?**

**How often do you remove your hair?**      Twice Daily      Daily      Weekly      Other

**Do you have sensitive skin?**      Yes      No

**Do you have scars in the area to be treated?**      Yes      No

**Have you ever been on Accutane?**      Yes      For how long:

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**Do you have a hormonal problem for which you have been treated?**      Yes      No

**If Yes, what was the treatment?**

**Have you had your testosterone levels checked?**      Yes      No

**What is your menstrual cycle like?**

Regular      Irregular      Menopause      Hysterectomy      N/A

**Are you possibly pregnant?**      Yes      No      N/A

**Do you make keloids (raised scar tissue) when you scar?**      Yes      No

**Have you ever had laser resurfacing?**      Yes      When?

**Have you ever had Microdermabrasion?**      Yes      No

**Have you ever had a chemical peel in the area of treatment?**      Yes      When?

**Do you get cold sores?**      Yes      No

**Have you ever had genital herpes?**      Yes      No

**Do you take any medications that make you feel sensitive to light?**      Yes      No

**Do you ever get light triggered headaches?**      Yes      No

**What medications/herbal supplements/topical creams do you use?**

**Please list any allergies you have:**

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Do you have a family history of Hirsutism (over abundance of hair)?      Yes      No

Do you have any current skin infections?      Yes      Please Describe

Please score yourself on the following questions to help us determine your skin type:

Score	0	1	2	3	4
What is the colour of your eyes	Light blue, grey, green	Blue, grey or green	Blue	Dark brown	Brownish black
What is the natural colour of your hair?	Sandy red	Blonde	Chestnut, dark blonde	Dark brown	Black
What colour is your skin in non-exposed areas?	Reddish	Very pale	Pale with beige tint	Light brown	Dark brown
Do you have freckles in non-exposed areas?	Many	Several	Few	Incidental	None
What happens when you stay in the sun too long?	Painful, blistering, redness, peeling	Burns followed by peeling	Burns sometimes followed by peeling	Rare burns	Never had burns
To what degree do you turn brown?	Hardly to not at all	Light colour tan	Reasonable tan	Tan very easily	Turn dark brown
Do you turn brown within several hours after sun exposure?	Hardly or not at all	Seldom	Sometimes	Often	Always
How does your face react to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem
When did you last expose your body to the sun or a sun bed?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than 1 month ago	Less than 2 weeks ago
Did you expose the area to be treated to the sun?	Never	Hardly ever	Sometimes	Often	Always

Skin Type Score	Fitzpatrick Type
0-7	I
8-16	II
17-25	III
26-30	IV
Over 30	V

**Add up the total score of questions:**

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**Clinic staff to complete this portion:**

**Hair to be treated is:**

Black      Brown      Grey      White      Villous      Coarse

**Photos:**      Yes      No