Confidential Case History

Date:_____

Name:_____

Address:_____

City/State/Zip:_____

Email Address:_____

Phone:_____Text? Y or N

Birthdate:_____ Age:_____ Gender:_____

Areas you'd like treated:_____

Temporary Hair Removal Methods Previously used:

Tweezing	Waxing	Depilatory Creams	Shaving
Sugaring	Threading	Bleaching	Laser

Have you had Electrolysis done before?_____ If so, how long ago and how often?_____

MEDICATIONS THAT MAY POSSIBLY AFFECT HAIR GROWTH

Type	**Y or N**	**Please List**
Hormones	Y or N	
Birth Control	Y or N	
Blood Pressure Medication	Y or N	
Anti-Seizure Medication	Y or N	
Steroids	Y or N	
Asthma Meds	Y or N	
Rosacea Meds	Y or N	
Cancer Meds	Y or N	
Spironolactone	Y or N	

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Health Conditions

Diabetic/Insulin Resistant	Y or N	How do you control it?
Hepatitis/HIV	Y or N	Meds?
Cold Sores/Fever Blisters/Herpes	Y or N	Meds?
Acne/Rosacea	Y or N	Meds?
Blood Clotting Disorder/Bruise easily	Y or N	
Heart Pacemaker or Defibrillator	Y or N	
Metal in your body/Body Piercings/IUD	Y or N	
Warts	Y or N	In work area?
Circulatory Disorder/Cold Feet	Y or N	Describe:
Are you Pregnant?	Y or N	
Any allergies/Sensitivities	Y or N	List:
Hysterectomy	Y or N	If yes, do you have ovaries?
PCOS? Polycystic Ovarian Syndrome	Y or N	Doctor Diagnosed?
Cancer	Y or N	

Have you had any cosmetic injections recently? (Botox, dermal fillers, Juvederm, etc) _____We'll need to avoid those areas which have been treated.

Any other health conditions we should be aware of?_____

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Acknowledgment of Information (Please initial each paragraph)

I understand health history is important to the Electrologist in order to provide me with safe and effective electrolysis 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.

_____

I understand that a series of treatments is necessary to achieve permanent hair removal based on my previous temporary methods of hair removal, the science of electrology and my individual physiological factors.

_____

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

_____

Permission to photograph the area to be treated? Yes or No _____(please initial)

Client Signature:_____

Parent or Guardian Signature for Minor:_____

Date:_____