THE DAY SPA AT SALON ELIZABETH INC. CONFIDENTIAL CLIENT ANALYSIS RECORD

Print Name:_____ Date of Birth:___/___/___Date 1st Visit:___/___/___
Address:_____ City:_____State:_____ Zip Code:_____
Home Phone:_____ Recommended By:_____
Office Phone:_____ Occupation:_____
Cell Phone:_____ Physician:_____Phone:_____
E-MAIL:_____

EMERGENCY CONTACT_____Relationship_____PHONE_____

Yes or No If: Previous Hair Removal Treatment: Electrolysis ____ Laser ____

Yes or No If: Used Previously: Bleaches___ Scissors___ Depilatories___ Tweezers___ Wax___ Razors___ Other_____

GENERAL HEALTH RECORD	**YES or NO**	
Any Cancer Including Skin	_____	Explain: _____
Burning,Itching Skin	_____	Explain: _____
Warts	_____	Explain: _____
Menopause/Hormone Problems	_____	Explain: _____
Heart Problems/Pacemaker	_____	Explain: _____
Medications You Take	_____	Explain: _____
Plastic or Laser Surgery	_____	Explain: _____
Any Other Recent Surgery	_____	Explain: _____
Cosmetic Implants,Pins	_____	Explain: _____
Retina A/Accutane	_____	Explain: _____
Allergies	_____	Explain: _____
Claustrophobic	_____	Explain: _____
Asthmatic	_____	
Nervous Tension	_____	
Sinus Headache	_____	
Trouble Sleeping	_____	
Wear Contact Lenses	_____	
Smoke	_____	
Had Botox or fillers	_____	
Exposed to Sun or Sun Beds	_____	
Use Glycolic Acid	_____	
Acid Peel	_____	
PRP/Microdermobrasion	_____	

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

Arthritic:_____ Hodgkins:_____ Pregnant:_____
Diabetic:_____ Rheumatic Fever:_____
Epileptic:_____ Hemophiliac:_____
Hepatitis:_____ HIV _____ AIDS:_____
Products you use to cleanse face_____
When was your last Facial:_____

Had a Professional Massage	_____	Have you had a Fall/Accident	_____
Had any Broken Bones	_____	Sensitive to Touch Anywhere	_____
Low Back Pain	_____	Pain down Arms or Legs	_____
Any Spinal Problems	_____	Blood Clots	_____
Chronic Bowel Problems	_____		

Explain:_____
_____
_____
_____

Professional Skin Analysis: Below to be FILLED OUT by Technician

Notes:_____

Dry:_____ Rosacea:_____ Lrg. Pores:_____ Psoriasis:_____ Pits:_____
Mature Dry:_____ Acne:_____ Eczema:_____ Capillaries:_____ Scars:_____
Oily:_____ Sensitive:_____ Moles:_____ Lines:_____ Freckling:_____

Normal:_____ Blemished:_____ Pigmentation:___ Wrinkles:_____ Chloasma:_____
Combination:_____ Crepe Neck:_____ Skin Tags:_____ White/Black Heads Hirsutism:_____

CLIENT TREATMENT CONSENT AND RELEASE FORM

Required Insurance Treatment Consent and Release Form:

I acknowledge that beauty and spa treatments treatments including, but not limited to: skin care, massage, waxing, hair or scalp treatments, nail treatments, electrolysis, facial toning, microneedling, body treatments, ionization, brown spot removal, and various other beauty procedures is not an exact science and no specific guarantees can or have been made concerning the outcome. I understand some clients experience more change and improvement than others. In virtually all cases, multiple treatments are required in order to realize a difference. On behalf of myself, my heirs, my executors, and my administrators, I understand and agree to the following risks and hazards which may occur in connection with any particular treatment including but not limited to: unsatisfactory results, soreness, poor healing, discomfort, redness, blistering, skin damage, nerve damage, disability, death, scarring, infection, change in skin pigmentation, allergic reaction, eye damage, change or damage to my vision, muscle damage and any increased hair growth.

I understand that even though precautions may be taken in my treatment, not all risks can be known in advance. Given the above, I understand that response varies to treatment varies on an individual basis and that specific results are not guaranteed. Therefore, in consideration for any treatment received, I agree to unconditionally defend, indemnify hold harmless and release from any and all liability, costs of litigation and any other costs of every kind and nature, the company the the individual that provided my treatment, the insured, their insurance company, and any additional insureds, as well as any officers, directors or employees of the above companies for any injury, property damage, condition or result, known or unknown, that may arise as a consequence of any treatment that I receive. The release contained herin will be construed to apply to the greatest extent permitted by law and, if permitted by law, will apply even if any such injury or damage is caused in whole or in part by the released parties' own negligence or the negligence or willful conduct of any other individual. In the event any provision of this agreement is found to be legally invalid or unenforceable for any reason, all remaining provisions will remain in full force and effect. In the event any provision of this document is found by a court of competent jurisdiction to exceed the limits permitted by any applicable law or to be invalid or unenforecable as written, such court (s) may excercise its discretion in reforming such provision (s) to the extent necessary to make it reasonable and enforceable. I understand and agree that any legal action of any kind related to any treatment I receive will be limited to binding arbitration using a single arbitrator agreed to by both parties. It is understood that any such arbitration will be final and binding and that by agreeing to arbitration, the undersigned is waiving their rights to seek remedies in court, including the right to a jury trial. The undersigned waives, to the fullest extent permitted by law, any right they may have to a trial by jury in any legal proceeding directly or indirectly arising out of or relating to this agreement whether based in contract, tort, statute (including any federal or state statute, law, ordinance, or regulation), or any other legal theory. The insured agrees that this contract will be governed and construed in accordance with the laws of the state of south Dakota and that all actions of any kind whatsoever will be heard, governed, arbitrated, and restricted to the venue of the County of Meade County, South Dakota. The undersigned also agrees and stipulates that they will be responsible for any legal, or other costs of any kind, incurred by the insured or their insurance company in defense of this agreement should the undersigned challenge its enforceability. The client indicated below also agrees to forever hold harmless and release from any and all liability, claims, or demands of any kind or nature the insured, and their insurance company for the transmission of any disease, condition, injury or illness they may allege to have contracted or been exposed to as the result of any treatment, person, or visit at the insured's location or the location of treatment. I have fully disclosed on my client intake form any medications, previous complications, or current conditions that may effect my treatment. In consideration for treatment received, I hearby grant permission to the individual or company that provided my treatment to use any photographic treatment records for the purposes of clinical and statistical studies, advertising, or promotion without any additional compensation to me

I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session and I will be liable for payment of the scheduled appointment.

Print Name: _____

Signature: _____ Date: _____

REMARKS

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Revised 2/23