About Skin Spa New Client Intake Release for Laser Hair Removal

Name _____

Date Jan / 01 / 2025

Date of Birth Jan / 01 / 1970

Address _____ **City** _____

State Florida **Zip Code** _____

Home/Cell (_____) _____ - _____ **Email** _____ @ _____

Emergency Contact Name _____

Emergency Contact Phone Number (_____) _____ - _____

To provide you with the most appropriate laser treatment, please complete the following questionnaire for About Skin Spa. All information is strictly confidential & follows HIPPA compliance.

Procedure Name: _____

No. of Visits Required: _____ **Cost of Procedure: $** _____

Medical History

Are you currently under the care of a primary physician? ☐ Yes ☐ No

Physician Name: _____

Physician Address: _____

Physician Phone Number: (_____) _____ - _____

Are you currently under the care of a non-primary care physician/specialist? ☐ Yes ☐ No

If yes, please describe:

_____

_____

Are you currently under the care of a dermatologist? ☐ Yes ☐ No

If yes, please describe:

_____

_____

Have you ever had an allergic reaction to any of the following? (*Please check all that apply*) ☐ Yes ☐ No

☐ - Food ☐ - Latex ☐ - Aspirin ☐ - Lidocaine ☐ - Hydrocortisone ☐ - Hydroquinone/Skin Bleaching Agents

☐ - Other: _____

If yes, please describe the reaction you experienced:

_____

_____

Have you ever had laser hair removal? ☐ Yes ☐ No

If yes, what treatment did you have and when?

_____

_____

Have you used any of the following hair removal methods in the past six weeks? (*Please check all that apply*)

☐ - Shaving ☐ - Waxing ☐ - Electrolysis ☐ - Tweezing ☐ - Stringing ☐ - Depilatories

Have you had any recent tanning or sun exposure that changed the color of your skin? ☐ Yes ☐ No

Have you recently used any self-tanning lotions or treatments? ☐ Yes ☐ No

Do you form thick or raised scars from cuts or burns? ☐ Yes ☐ No

If yes, where & how old are the scars?

_____

_____

Do you have Hyperpigmentation (*darkening of the skin*) **or Hypopigmentation** (*lightening of the skin*) **or marks after physical trauma?**

☐ Yes ☐ No

If yes, please describe:

_____

_____

Do you have any illnesses at present? ☐ Yes ☐ No

If yes, please describe:

_____

_____

Do you have a family history of cancer? ☐ Yes ☐ No

If yes, please describe:

_____

_____

Do you have problems healing from a cut or a burn? ☐ Yes ☐ No

If yes, please describe:

_____

_____

Have you ever had a histamine reaction to the sun? ☐ Yes ☐ No

If yes, please describe:

_____

_____

Do you have any tattoos or permanent cosmetics? ☐ Yes ☐ No If yes, please

describe:

_____

_____

Have you ever been treated with BOTOX or other injectables? ☐ Yes ☐ No

If yes, please describe:

_____

_____

Do you have herpes, or have you ever had a "cold sore"? ☐ Yes ☐ No

If yes, please describe:

_____

_____

Have you been diagnosed with Polycystic Ovarian Syndrome (PCOS)? ☐ Yes ☐ No

If yes, please describe:

_____

_____

Are you currently using BHA/AHA (Glycolic or Salicylic) products? ☐ Yes ☐ No

If yes, please describe:

_____

_____

What oral medications are you presently taking? (*Please check all that apply*)

☐ - Birth Control Pills ☐ - Hormone Replacements ☐ - Anti-Depressants ☐ - Blood Pressure Medications

☐ - Mood Stabilizers ☐ - Acne Medication

☐ - Other(s) _____

Have you ever used Accutane? ☐ Yes ☐ No

☐ If yes, when did you last use it? _____

What topical medications or creams are you currently using? (*Please list all brands & the frequency*)

_____

_____

_____

_____

What herbal supplements (either over the counter or prescribed) do you use regularly? (*Please list all brands & the frequency*)

_____

_____

_____

_____

Acknowledgement

- I have received pre- & post-procedure instructions, & I will strictly adhere to such instructions. I understand that my failure to do so may jeopardize my chances for a successful procedure. If I am on any medication for acne, mood alteration or blood pressure I will immediately notify my esthetician as this could adversely affect blood flow & the healing process. _____ (*initial*)
- I am not using any photosensitizing drugs or products or have had the risks explained to me & given my consent to continue treatment. _____ (*initial*)
- I understand the UV exposure 7 days pre- or post-treatment greatly increases my risks of experiencing side effects from the laser treatment. _____ (*initial*)
- I have been informed that my treatment results may vary if I am pregnant or nursing. I have disclosed my pregnancy status to ***About Skin Spa*** & have provided a waiver of treatment approval from my physician. I agree that if my status changes I will inform ***About Skin Spa*** immediately & prior to treatment. _____ (*initial*)
- I have reviewed & understand what to expect from my treatment & the potential risks associated with said treatment. I also understand the potential side effects I may experience due to this treatment. _____ (*initial*)
- I have received & reviewed the pre- & post-care instructions for the treatments I will be receiving. _____ (*initial*)
- I understand that ***About Skin Spa*** does not guarantee any specific results from my treatment. I have reviewed & understand the limitations of the treatments I will be receiving. I am aware that laser hair removal treatments are not effective on RED, BLONDE, or GREY hair. _____ (*initial*)
- I understand that, on average, laser hair removal clients may expect 70% - 90% reduction after 8-12 & sometimes more treatments. _____ (*initial*)
- I agree that if I experience any side effects from my treatments that I will contact ***About Skin Spa*** & allow them to review & treat my condition to the best of their ability. If I chose to visit another provider without allowing ***About Skin Spa*** to first review my treatment plan than ***About Skin Spa*** may not be held liable for any reimbursement of care. _____ (*initial*)
- I consent to being treated with the products determined necessary by ***About Skin Spa***. I have informed ***About Skin Spa*** of any known product & medication allergies that I may have. _____ (*initial*)
- I understand that I cannot have any laser services if I have used Isotretinoin (Accutane, Amnesteem, Claravis, Sotret) within the last 6 months/182 days. _____ (*initial*)
- I understand that ***About Skin Spa*** does not provide medical diagnoses & that I must provide an accurate medical history. _____ (*initial*)
- I understand that before & after photographs may be taken for documentation in my client record. I hereby give consent to ***About Skin Spa*** to take photographs of me as needed during my treatments. I authorize ***About Skin Spa*** to use such photographs for purposes of training, professional publication, education or marketing. I understand that the taking of before & after photographs of the said procedure(s) are a condition of said procedure(s) & will be used in my esthetician's portfolio. _____ (*initial*)
- I certify that I have read, fully understand the above paragraphs. I understand & consent to the laser hair removal procedure. I accept full responsibility for the decision to have this laser hair removal work completed. _____ (*initial*)
- I voluntarily consent to receive treatment ("services") at ***About Skin Spa***. _____ (*initial*)
- I am aware the ***About Skin Spa*** holds my treatment records under HIPPA standards unless I give permission/consent to release. _____ (*initial*)
- I understand that to keep prices low ***About Skin Spa*** requires a minimum of 24 hours' notice for cancellation or rescheduling. If I do not

follow this policy I will be charged half (½) of the total cost of my appointment. I will not be able to book/schedule another appointment with ***About Skin Spa*** until my account balance is $0.00. I understand that I will be responsible for paying all costs & expenses associated with my failure to pay any amounts owed to ***About Skin Spa***, including all returned check fees, reasonable attorney fees, court costs, &any other related collection costs & expenses. _____ (*initial*)

- Any & all controversies, disputes or disagreements relating to or arising out of this agreement, including personal injury resulting from services received, shall be submitted to binding arbitration according to the rules & regulations of the American Arbitration Association, & binding judgement based on the decision of the arbitrator may be entered in any court of competent jurisdiction. _____ (*initial*)
- I understand that ***About Skin Spa*** does not guarantee results or make any promises as to the effectiveness of my treatment. I understand that the required number of treatments varies for each client & for each type of treatment. I understand that ***About Skin Spa*** will not refund my purchase due to less than average results or because I experience side effects from treatments. _____ (*initial*)
- I certify that the preceding medical, personal & skin history statements are true & correct. I am aware that it is my responsibility to inform the technician or esthetician of my current medical or health conditions & to update this history. Current medical history is essential for ***About Skin Spa*** to execute appropriate treatment procedures. _____ (*initial*)

Client: _____ **Date** Jan / 01 / 1970

Driver's License No: _____

Driver's Lic. Issuing State: FL **Driver's Lic. Exp. Date** Jan / 01 / 1970

Esthetician: _____ **Date** Jan / 01 / 1970