Chemical Peel

Consultation Form

Email/Newsletter

Would you like to be added to our subscriber list in order to receive information about upcoming discounts,promotions, contests etc.?

○ ***Yes, subscribe me!***

○ ***No, thanks.***

Appointment date _____ Appointment time _____

Personal Information

Full Name:

D.O.B.: Age: Phone #:

Address:

To perform the Skin Chemical Peel in a safe manner, please answer the following health questions truthfully. We will keep all information disclosed in a confidential manner and will use it only for purposes of determining whether you are an ideal candidate for this procedure.

Have you ever had chemical peels, microdermabrasion, or any resurfacing treatments previously? ☐Yes ☐No

If yes, please specify. . . . . . .

What would you like to achieve from your treatment today?

. . . . . .

SKIN EVALUATION

	Poor	*Fair*	*Good*	*Excellent*
Moisture content	☐	☐	☐	☐
Muscle tone	☐	☐	☐	☐
Elasticity	☐	☐	☐	☐
Skins healing ability	☐	☐	☐	☐

How would you describe your skin?

☐Normal ☐Dry ☐Oily ☐Combi ☐Sensitive
☐Breakouts ☐Acne ☐Mature

Do you burn easily in moderate sun? ☐Yes ☐No
Do you have a tendency to redness? ☐Yes ☐No
Do you suffer from sinus problems? ☐Yes ☐No

Do you have any special skin problems or concerns pertaining to your face of body? ☐Yes ☐No
If yes, please specify. . . . . . .

Have you experienced Botox, Restylane or Collagen injections? ☐Yes ☐No
If yes, please specify. . . . . . .

Do you ever experience burning, itching or stinging sensations on your skin? ☐Yes ☐No

Do you ever experience these conditions on your skin?

☐Flakiness ☐Tightness ☐Obvious dryness
☐Excessive oily shine during the day

List any medications, supplements, vitamins, diuretics, slimming tablets etc. that you take regularly . . . . . .

What skin care products are you currently using?

Face:

☐Soap ☐Moisturiser
☐Toner ☐Exfoliator
☐Masque ☐Serum
☐Cleanser ☐Eye Product

Body:

☐Soap ☐Moisturiser
☐Shower gel ☐Tanners
☐Scrubs ☐Depilatory products
☐Oil

Are you currently using any products that contain the following ingredients?

☐Glycolic acid

☐Lactic acid

☐Any exfoliating scrubs

☐Any hydroxy acid product

☐Vitamin A derivatives (i.e. Retinol)

☐Ratin-A

☐Renova

☐Adapalene

☐Accutane

Have you had any of the following procedures in the last 48 hours?

☐Clay Masks
☐Self-Tanning Agents
☐Hair Removal
☐Retin-A or Vitamin A

HEALTH EVALUATION

How would you describe your overall health?

☐Excellent ☐Good ☐Fair ☐Poor

Do you smoke?	☐Yes	☐No
Do you exercise regularly?	☐Yes	☐No
Do you follow a strict diet?	☐Yes	☐No
Do you wear contact lenses?	☐Yes	☐No
Do you have metal implants, a pacemaker or body piercing?	☐Yes	☐No

Rate your level of stress on a scale of 1 to 4 (1= low stress, 4= high stress). . . . . .

Have you ever had reactions to any of the following?

☐Cosmetic ☐Animals
☐Medicine ☐Hydroxy acid
☐Fragrance ☐Sunscreen
☐Pollen ☐Food
☐Other. . . . . .

Men only

Do you suffer from ingrown facial hair?	☐Yes	☐No
Experience razor burn?	☐Yes	☐No
What is your current shaving system?	☐Wet	☐Electric

PLEASE ENSURE:

_____ The skin care specialist has explained the peel and contraindications of this form to me and I fully understand and agree with the consultation.
_____ I understand a mild redness or slight irritation may occur temporarily and subside.
_____ I understand the maximum results from a peel will be achieved with a course- generally 6 peels, in conjunction with homecare products.
_____ I understand due to the variable nature of the skin, no guarantee can be made to me regarding the results of treatment.
_____ I confirm that I have a copy of the pre and post peel instruction sheet.

This form is completely confidential. Completion of form gives the general state of health and assists our specialist in directing a customized course of treatment for you.

The information I have provided about my medical history is accurate to the best of my knowledge. I agree to accept responsibility for omissions regarding my failure to disclose any existing or past health conditions.

Date:
Client Signature _____ Therapist Signature _____

Please, indicate if you are having any of the following:

☐Recent cosmetic surgery, laser resurfacing, deep or medium depth chemical peels or dermabrasion
☐Rosacea
☐Easily scars
☐Pregnancy
☐Menopause
☐Breast-feeding
☐Irritated skin
☐Open sores or lesions
☐Infectious disease
☐Active Herpes simplex
☐Diabetes
☐High blood pressure
☐Heart disease
☐Deficient immune system
☐Fever
☐Skin cancer
☐Dermatitis
☐Hepatitis
☐Eczema
☐Inflammation
☐Active acne
☐Cuts
☐Bruises
☐Abrasions
☐Sunburn
☐Pigmentation disorder
☐Asthma
☐Varicose veins
☐Epilepsy

Within the last year, have you been under dermatologist or other physician's care?

☐Yes ☐No

Chemical Peel

Client Treatment Plan

Client Name _____

I recommend the following professional treatments for you to help achieve the results you desire:

Date:

Treatment type _____

Schedule every……..days/weeks

……..series recommended of……..# of treatment

Date scheduled:

Date:

Treatment type _____

Schedule every……..days/weeks

……..series recommended of……..# of treatment

Date scheduled:

Date:

Treatment type _____

Schedule every……..days/weeks

……..series recommended of……..# of treatment

Date scheduled:

HOME CARE

Cleanser:	How often:
Exfoliant:	How often:
Serum:	How often:
Moisturizer:	How often:
SPF:	How often:
Repair Tx:	How often:
Masque:	How often:
Spot Tx:	How often:
Other:	How often:

If you have any questions about your treatment plan, or when and how to use your home care products, please contact me any time. Your treatment plan may change depending on the rate of progress and changes in your skin.

___(initial) I understand that to achieve maximum benefits and maintain the results from my professional treatments, home care product use as outlined above is essential.

___I commit to my success by pledging to wear sunscreen daily.

Client Signature Therapist Signature

Consent Form

I, _____, have read the below information and initialed each section to indicate that I fully understand what to expect. If I have any questions or concerns, I will address these with my skin therapist. I give permission to my skin therapist, _____, to perform the chemical treatment we have discussed and will hold him/her and his/her staff harmless from any liability that may result from this treatment.

I understand my skin therapist will take every precaution to minimize or eliminate negative reactions such as blisters, sores, or other reactions, as much as possible. I do understand that, very rarely, permanent damage occurs. I have given an accurate account of any over-the-counter or prescription medications that I use regularly, and I am not presently using (nor have I used within the last year) isotretinoin (Accutane), Retin-A, Acyclovir or tranquilizers. I have not had any facial surgical procedures, piercings, tattoos, permanent cosmetics, or other chemical peels or skin treatments that I have not disclosed to my skin therapist. I am not ingesting or using topically any other over-the-counter product or prescription medication/agent that has not been disclosed to my skin therapist. I am not presently pregnant or lactating and I am over the age of eighteen (18). I have not had any recent radioactive or chemotherapy treatments, sunburn, windburn or broken skin. I have not recently waxed or used a depilatory on the area to be treated. I do not have a history of keloidal scarring, diabetes, any auto immune disease, active herpes blisters, or any other existing condition that may interfere with the positive outcome of this treatment.

_____ I understand that I should not have a chemical peel if I intend to continue to have excessive sun exposure. It has been explained to me that the treated area will be more sensitive to the sun as a result of the treatment and will require regular use of sunscreen.

_____ I consent to the taking of photographs to monitor treatment effects, as desired or recommended by my therapist.

_____My expectations are realistic and I understand that the results are not guaranteed and that for maximum results, more than one application may be required. The rate of improvement of my skin depends on my age, skin type and condition, degree of sun/environmental damage, pigmentation levels, or acne condition.

_____I understand that this procedure is expected to make the skin feel uncomfortable while being applied, but agree to inform the skin professional immediately if I have concerns or am overly uncomfortable during treatment or after I return home.

_____ I agree that I am willing to follow recommendations by my therapist for home care. I will be responsible for following home regimens that can minimize or eliminate possible negative reactions, including recognizing the importance of adhering to a sunscreen and avoiding the sun/tanning booths and extreme weather conditions. I agree to use a moisturizer specifically recommended by my therapist and I acknowledge that I have been informed of the possible negative reactions (intense erythema, welts, scabs) and the expected sequence of the healing process (dryness, irritation, redness, and peeling of the skin). In the event that I may have additional questions or concerns regarding my treatment or suggested home product/post-treatment care, I will consult my therapist immediately.

_____I understand the potential risks and complications and have chosen to proceed with the treatment after careful consideration of the possibility of both known and unknown risks, complications, and limitations. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read, and fully understand the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered.

Date:

Client Name (Printed) _____ Therapist Name _____

Client Signature _____ Therapist Signature_____

PHOTO & VIDEO RELEASE FORM

I,_____, hereby grant and authorize _____ the right to take, edit, alter, copy, exhibit, publish, distribute and make use of any and all pictures, video, and/ or audio taken of me to be used in and/ or for any lawful promotional materials including, but not limited to, newsletters, flyers, posters, brochures, advertisements, press kits, websites, social media sites and other print or digital communications without payment or any other consideration.

This authorization extends to all languages, media, formats, and markets now known and later discovered.

I will be consulted about the use of the photograph and/ or video recording for any purpose other than those listed below:

- promotional materials;
- printed and/ or digital advertisements;educational presentations or courses; informational presentations;
- online educational courses;educational videos;
- social media posts.

There is no time limit on the validity of this release nor is there any geographic limitation on where these materials may be distributed.

By signing this form I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims againstany person or organization utilizing this material for educational purposes.

Date: _____

Client Full Name (Printed) _____

Client Signature _____

COVID-19 LIABILITY RELEASE WAIVER

This forms must be completed and signed before treatment

The World Health Organization has declared the novel Coronavirus (COVID-19) a worldwide pandemic. Due to its capacity to transmit from person-to-person through respiratory droplets, the government has set recommendations, guidelines, and some prohibitions
which _____ adheres to comply.

Symptoms of COVID-19:

- Fever, Fatigue, Dry cough, Difficulty to breath

I agree to following:

☐ I, nor members of my household, have not experienced any of the symptoms listed within the last 14 days.

☐ I, nor members of my household, have not travelled internationally in the last 30 days.

☐ I, nor members of my household, do not believe that we have been exposed to someone with a suspected and/or confirmed case of Coronavirus (COVID-19).

☐ I, nor members of my household, have not been diagnosed with the Coronavirus (COVID-19) within the last 30 days.

☐ The venue cannot be held liable from any exposure to the Coronavirus (COVID-19) caused by misinformation on this forms or the health history provided by each client.

☐ I understand that due to the frequency of visits of other clients, the characteristics of the virus, and characteristics of these services that I have elevated risk of contracting the virus simply by being in the establishment.

To prevent the spread of the contagious virus and to help protect each other, I understand that I must follow the establishment's guidelines:

- Reschedule appointment if you are feeling unwell;
- No additional guest is allowed;
- Wash hands upon arrival;
- Limit conversation during the procedure.
-

By signing below, I agree to each above statement and release the venue and its employees from any and all liability for the unintentional exposure or harm due to the Coronavirus (COVID-19) and other communicable conditions.

Date: _____

Client Full Name (Printed) _____

Client Signature _____

APPOINTMENT CANCELLATION POLICY

Dear Client,

We strive to render excellent care to you and the rest of our clients. Your careand treatment is a priority for us. We also ask that you respect your specialist's time and expertise as well.

In an attempt to be consistent with this, we have a Cancellation Policy that allows us to schedule appointments for our clients, with respect for your time, thenext client's time, and the specialist's time.

Our policy is as follows:

We request that you give a notice not later **than 24 hours** before scheduled appointment in the event that you cannot make it. If the client misses anappointment without contacting us, it is considered a missed or "No Show"appointment. Additionally, if a client is more than 15 minutes late for an appointment, it will be considered as "No Show" appointment, and that appointment will be rescheduled. Also, if you miss more than 3 appointments, we reserve the right to charge you a fee of _____

A _____ non-refundable deposit will be paid at time of making appointment

and will be taken off at the time of the appointment.

If you have questions regarding this policy, please let us know, and we will be happy to clarify our policy for you.

I have read and understand the Appointment Cancellation Policy, and I agree to be bound by its terms. I am aware that my credit card will be charged for the missedappointment, and I agree to these terms.

I, _____ , have received the copy of Cancellation Policy.

Date: _____

Client Full Name (Printed) _____

Client Signature _____

CHEMICAL PEEL

Pre-treatment Advices

Avoid sun exposure prior to treatment. Sunburned skin cannot be treated.

Do not bleach, wax, tweeze or use depilatory creams in treatment area for 3 days prior to treatment

Discontinue use of retinoid (Retin A, Tazorac, Differin, etc) and Hydroquinone products 3 days prior to treatment

Discontinue use of 10% or higher Alpha Hydroxyl Acids, Glycolic Acids, and exfoliants 3 days prior to peel

If you have a history of perioral herpes, advise office so you may begin prophylactic antiviral therapy the day before treatment

Schedule your injection at a time when minor swelling or peeling will not disrupt your social obligations

Contact me if you have any questions:

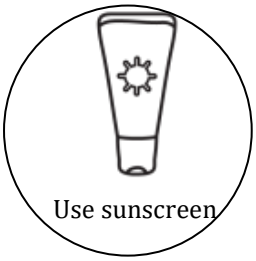
813-438-3877

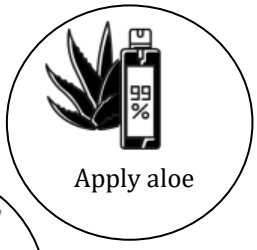
CHEMICAL PEEL

Aftercare Advices

GENERAL

- Wash your face daily with gentle cleanser.
- For AM don't forget your SPF 30 (minimum) sunblock DAILY.
- For a few days skin may feel dry, flaky and pink or red in appearance.
- Can use powder or mineral makeup ONLY as soon as the next day.
- No liquid or cream makeup for 1 week after peel.
- Apply antioxidants for soothing and hydration of the skin.





**These timelines are approximate and precautions should be extended beyond the recommended time if skin remains sensitive.*

72 HOURS AFTER TREATMENT

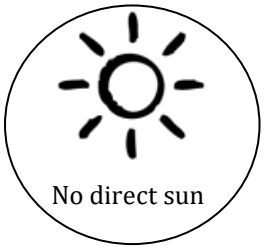
***DO NOT USE** any of the following products:*

- Alpha or Beta Hydroxy
- Salicylic Acid/ Salicylate
- Retin – A
- Glycolics

Use warm or tepid water on area treated: **DO NOT** use hot water.
DO NOT submerge area treated in chlorinated pool or tub water.

FOR 10-14 DAYS AFTER TREATMENT

Stay out of direct sunlight. If you must be outdoors, use sunscreen.
DO NOT have any other skin peel, Microdermabrasion or Chemical Peel, unsless you are following specific protocol.
DO NOT have waxing, Botox or collagen treatments.
AVOID excessive heat sources (sun exposure or dry sauna and steam rooms).



AVOID any activities that could lead to increased blood circulation to the face.
Peeling will start 3-5 days after peel. **DO NOT** pick or scratch at treated skin but instead keep moisturized.