Consultation Form

Appointment date --/--/--

Appointment time --:--

Personal Information

FULL NAME

D.O.B. AGE PHONE #

ADDRESS

EMAIL / NEWSLETTER

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

◯ YES! Sign me up!

◯ No, thanks

Have you ever experienced the following?

☐ Professional facials ☐ Glycolic Peels ☐ Salicylic Peels
☐ Microdermabrasion ☐ Laser hair removal ☐ Other .....

What would you like to achieve from your treatment today?

.....

MEDICAL INFORMATION

☐ Diabetes ☐ Hemophiliac ☐ Circulatory
☐ Epilepsy ☐ Pregnant ☐ Hypertension
☐ Heart disease ☐ Cortisone ☐ I.D.U.
☐ Virus ☐ Anticoagulants ☐ Glandular
☐ Pacemaker ☐ Hormonal treatments ☐ Metallic implants

Skin disease:

Are you prone to Herpes out brakes? ☐ Yes ☐ No
Are you pregnant or lactating? ☐ Yes ☐ No

Please list all medications you take internally, include Accutane (and when last taken):

.....

.....

Please list any medications that you regularly use topically, include Retin-A, AHAs:

.....

.....

Do you have any allergies? ☐ Yes ☐ No

.....

How much sun exposure do you receive?

☐ A lot ☐ Average ☐ Minimal

Do you suffer from any of the following problems?

☐ Milia ☐ Eczema ☐ Moles
☐ Comedones ☐ Psoriasis ☐ Broken capillaries
☐ Acne ☐ Age spots on hand ☐ Warts
☐ Rosacea ☐ Hyperpigmentation

CONTRAINDICATIONS REQUIRING MEDICAL PERMISSION

☐ Pregnancy
☐ Cardiovascular conditions (thrombosis, phlebitis, hypertension, hypotension, heart conditions)
☐ Haemophilia
☐ Any condition already being treated by a GP or Dermatologist
☐ Medical oedema
☐ Osteoporosis
☐ Nervous/Psychotic conditions
☐ Epilepsy
☐ Recent operations
☐ Diabetes
☐ Asthma
☐ Bells Palsy
☐ Trapped/Pinched nerve
☐ Inflamed nerve
☐ Cancer
☐ Spastic conditions
☐ Undiagnosed pain
☐ When taking prescribed medication
☐ Recent cosmetic or other surgeryInjections for personal enhancement

SKIN EXAMINATION

☐ Pink	☐ Normal	☐ Young
☐ Asian	☐ Dry	☐ Mature
☐ Mediterranean	☐ Oily	☐ Aging
☐ Olive	☐ Combination	
☐ Black	☐ Dehydrated	
☐ White	☐ Sensitive	
☐ Mixed		

Secretions:

☐ Hypo	☐ Hyper	☐ Hyper

Sup. Wrinkles ..... Deep Wrinkles .....

Skin abnormalities .....

Scars ..... Date ..... Size ..... Color .....

Sensitivity ..... Pigmitation spot ..... Size ..... Color .....

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

REASON/S FOR TREATMENT

Removal of:

☐ Comodones	☐ Milia	☐ .....

Treatment of

☐ Fine lines	☐ Wrinkles	☐ Scars
☐ Lip lines	☐ Frown lines	☐ .....

Treatment details:

.....

.....

.....

.....

.....

.....

After/Home care advice given:

.....

CONTRAINDICTIONS THAT RESTRICT TREATMENT

- ☐ Fever
- ☐ Contagious or infectious diseases
- ☐ Under the influence of recreational drugs or alcohol
- ☐ Diarrhoea and vomiting Any known allergies
- ☐ Skin cancer
- ☐ Hepatitis Skin diseases
- ☐ Undiagnosed lumps and bumps
- ☐ Hypersensitive skin
- ☐ Broken capillaries
- ☐ Localised swelling
- ☐ Inflammation
- ☐ Cuts Bruises Abrasions
- ☐ Scar tissues (2 years for major operation and 6 months for a small scar)
- ☐ Sunburn
- ☐ Haematoma
- ☐ Recent fractures (minimum 3 months)
- ☐ Any metal pins or plates
- ☐ Loss of skin sensation (tactiletest)
- ☐ Botox/dermal fillers (1 week following treatment)

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 any existing or past health conditions.

Client Signature ..... Date .....

Therapist Signature ..... Date .....

Consent Form

This consent form is designed to verify that you have been satisfactorily informed and educated in respect to your microdermabrasion skin care treatment, as well as its aftercare, so that you may make an educated decision as to whether to have this procedure performed. This disclosure is not meant to alarm you; it is simply an effort to make you better informed so you may give, or withhold, or consent treatment. Please read and initial where indicated:

_____ (Initial) 1. I acknowledge having been informed that this cosmetic procedure is intended to remove superficial surface layers of the skin to improve the vitality of the skin.

_____ (Initial) 2. I understand that my skin care professional can discover other or different conditions that may require additional or different procedure that this planned. If my skin care professional discovers such other or different conditions I will be referred to an appropriate medical care provider.

_____ (Initial) 3. It has been explained that because microdermabrasion procedures are a superficial abrasion to the skin, the result of one-time treatment is similar to deep cleansing or polishing of the skin. I understand that in order to see significant results these treatments need to be done in a series and in combination with active ingredient skin care products.

_____ (Initial) 4. I acknowledge that while the goal of such procedure is the removal of damaged skin, the realistic results average at least fifty percent improvement. I acknowledge that the practice cosmetology is not an exact science and that no specific guarantees can or have been made concerning the expected results. Some clients' skin may show improvement, while others may not show marked improvement.

_____ (Initial) 5. I acknowledge that after my microdermabrasion procedure, all treated areas may feel warm and appear sunburned or my skin may experience a wind-burned sensation.

_____ (Initial) 6. I understand that my compliance to my aftercare instructions will greatly affect my final result. I acknowledge my obligation to follow the written and spoken instructions covering my pre- and post-treatment skin care regimen.

_____ (Initial) 7. I understand that multiple treatments may be required.

_____ (Initial) 8. I understand that although rare, certain risks or complications may occur but are usually treatable and temporary, such as hyper-pigmentation, hypo-pigmentation, and scarring. Following all post procedure instructions will help avoid conditions.

_____ (Initial)

9. I acknowledge that if I am prone to Herpes (cold sores, fever blisters) that I may need a prescription for Valtrex (acyclovir) from WSWH prior to having microdermabrasion. I need to avoid treatments during a breakout.

_____ (Initial)

10. I acknowledge that I have not used Accutane during the last six month.

_____ (Initial)

11. I acknowledge that I should avoid the use of glycolic and Retin-A products the day before, the day of, and 1 – 3 days following treatments.

_____ (Initial)

12. Acne patience, it has been explained to me that I may experience a slight acne flare-up, and that my acne condition may temporarily look worse for a few days after microdermabrasion treatment.

_____ (Initial)

13. I acknowledge that I have been instructed to avoid sun exposure and must wear a sun block of at least SPF 25 over the treated areas on a daily basis during my treatment series.

_____ (Initial)

14. I understand that if I have any additional questions or concerns that I should call my therapist immediately.

I have read and initiated each paragraph and have been satisfactorily informed of the benefits, risks, and complications regarding microdermabrasion. I consent to this microdermabrasion treatment today and for all subsequent microdermabrasion treatments.

Client Name (Printed) .....

Client Signature ..... Date .....

Parent/ Legal Guardian Signature (if the patient is minor) ..... Date .....

MICRODERMABRASION
post care instructions

- Your skin may have a slight rosy glow for approximately 24-48 hours. It may also have a “wind-burn” sensation if your skin is extremely sensitive. This can be more common in the colder/dryer months and gentle/calming products may be necessary to help with the sensation.
- Please use all gentle and benign products for the next 3-5 days after your treatment or until you feel as though you are no longer sensitive to your home care products.
- Cleanse and moisturize your skin twice daily along with any recommended home care products.
- It is recommended that other topical, over-the-counter medications or alpha hydroxy acids not be applied to the skin 1-2 days post procedure, as they may cause irritation.
- Discontinue use of any topical retinoids for at least 3 days after to your treatment or longer based on your sensitivity.
- Avoid direct sun exposure for 1-2 days after your treatment.
- Use a sunscreen every day that blocks both UVA and UVB rays, preferably one containing a SPF of 30 or higher (we recommend wearing a sunscreen everyday).
- Do not go tanning for at least 2 weeks post-procedure. This practice should be discontinued due to the increased risk of skin cancer and signs of aging.
- DO NOT pick or pull any loosening or peeling skin. This could potentially cause scaring or Hyperpigmentation.
- Do not have electrolysis, facial waxing and/or depilatories for approximately 1-2 weeks.

NOTE THAT EVERY ONE IS DIFFERENT IN THE RESULTS AS WELL AS THE POST TREATMENT RECOVERY PERIOD

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pre-care instructions

- Discontinue use of depilatories or waxing or any products or treatments that may irritate the skin for 1-2 weeks prior to your treatment.
- Discontinue sun exposure or use of tanning booths at least 14 days prior to your treatment (we recommend this practice is discontinued altogether).
- Discontinue use of any topical retinoids for at least 3-5 days prior to your treatment. This may include: tretinoin, Retin-A®, Renova®, Differin®, Tazorac®, Avage®, EpiDuo™, Ziana®).
- History of herpes or cold sores may require an anti-viral prescription prior to treatment.
- Some medications or supplements may increase sensitivity. Consult your physician.
- Please avoid any laser or electrolysis treatments (of any kind) at least 7 days prior to your treatment; unless otherwise recommended by your aesthetician.
- *It is your responsibility to notify your therapist of any changes to your health history or medications since your last appointment.

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COVID-19 LIABILITY RELEASE WAIVER

THIS FORM 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 ..... company name adheres to comply.

Symptoms of COVID-19 include:

- Fever
- Fatigue
- Dry Cough
- Difficulty Breathing

I agree to the following:

- ☐ I, nor members of my household, have not experienced any of the symptoms listed above 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 the 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 form 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 the characteristics of these services that I have an 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;
- Wearing a mask is required upon arrival and during the entire procedure;
- 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 Covid-19 and other communicable conditions.

Name (Printed) ..... Date --/--/--

Name (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 against any person or organization utilizing this material for educational purposes.

Full name _____

Street address/ P.O. Box _____

City _____ Postal Code _____

Email address _____ Phone _____

Signature _____ Date _____

APPOINTMENT CANCELLATION POLICY

Dear Client,

We strive to render excellent care to you and the rest of our clients. Your care and 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, the next 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** prior your scheduled appointment in the event that you can not make it. If the client misses an appointment 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 (three) 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 missed appointment, and I agree to this terms.

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

CREDIT CARD	NUMBER	EXP. DATE	CVV

Client Signature . . . . . .

Receptionist Signature . . . . . .

Date . . . . . .