SenzaPeloMedSpa
Professionalism, Dedication, Kindness And Compassion

CLIENT PROFILE

Legal Name: ______________________________ _________________DOB: ___________ _______________Gender: __________

Preferred Name:_______________________ Address: ____

City: ____ State: _______ Zip: ____________________

Primary Phone: (__________) __________--_________________ Secondary Phone: (__________) __________--________________

E-mail Address (please print): ____

Who shall we thank for the referral?____

In what services are you interested? __ Electrolysis __ Laser Hair Removal __ Electrodesiccation (blemish removal)

__ Aesthetic Nursing ((fillers & relaxers) __ Laser Rejuvenation __ Aesthetics __ IM Injections __ Permanent Makeup

Please Circle ALL "yes/no"
Would you like to receive our exclusive e-mail and text message promotions? (Please circle) YES NO
Medical Skin History

1. Do you have any permanent make-up or tattoos? **YES** **NO** Explain: ____________________________________
2. Have you recently prolonged sun exposure or artificial tanning within last four weeks *(all areas)*? **YES** **NO**
3. Are you currently using Retin-A/ Bleaching Agents? YES NO If yes, where was it applied?______________
4. Are you currently using or have you ever used Photosensitive medication such as Accutane? **YES** **NO**
   If yes, explain____
5. Have you ever had microdermabrasion or chemical peel? **YES** **NO** If yes, how long ago? ___________
6. Have you recently had facial surgery or laser resurfacing? **YES** NO If yes, how long ago? ___________
7. Do you smoke? YES NO
8. Do you get cold sores/fever blisters? **YES** **NO** If yes, last breakout? _______________
9. Are you sensitive to alcohol-based products? **YES** **NO**
10. List any items you are allergic/sensitive to: ____
11. Are you taking any other medications/ supplements/vitamins at this time? **YES** **NO**
    If yes, please list:
    ____
12. Do you have any medical conditions or autoimmune disorders? **YES** **NO**
    If yes, explain____
13. Upcoming medical procedures **YES** **NO**

Medical Hair History

Area(s) to be treated:____
____

1. Are you pregnant? **YES** **NO** Are you lactating? **YES** **NO**
2. Are you in or past menopause? **YES** **NO**
3. Do other family members have excessive hair? **YES** **NO** Relationship _________________________
4. Please list previous/current methods of hair removal ____
   How often are you using hair removal: ________ Last time you removed your unwanted hair _________
5. List previous laser/electrolysis treatments: First treat. date: _______________ Last treat. date _________________
   Electrolysis modality: Thermolysis _______ Blend _______ Galvanic _____Laser Type
____

Patient Signature: ____Date:____________________

SenzaPelo MedSpa

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HAIR REMOVAL & ELECTRODESSICATION Intake & Consent

Print Name:____ Date:________________

FITZPATRICK SKIN TYPE EVALUATION

SCORE	0	1	2	3	4	Your Score
Your natural eye color?	Light Blue, Gray, Green	Blue, Gray, Green	Dark Blue	Dark Brown	Brownish Black	
Natural color of hair being treated?	Sandy or Red	Blonde	Chestnut, Dark Blonde	Dark Brown	Black	
Color of your NON-EXPOSED skin?	Reddish	Very Pale	Pale with Beige Tint	Light Brown	None	
Do you have freckles on non-exposed areas?	Many	Several	Few	Incidental	None	

Genetic Disposition Score _________

SCORE	0	1	2	3	4	Your Score
What happens when you stay in the sun too long?	Painful redness, blistering, peeling	Blistering followed by peeling	Burn, sometimes followed by peeling	Rarely burn	Never burn	
To what degree do you turn brown?	Hardly or not at all	Light color tan	Reasonable tan	Tan very easily	Turn dark brown quickly	
Do you turn brown within several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always	
How does your face react to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem	

Sun Reaction Score ________

SCORE	0	1	2	3	4	Your Score
When did you <u>LAST EXPOSE</u> your body to the sun or tanning booth, or use tanning cream?	More than three months ago	Two to three months ago	One to two months ago	Less than one month	Less than two weeks	
Did you expose the area to be treated to the sun?	Never	Hardly ever	Sometimes	Often	Always	

Tanning Habits Score _____________ **TOTAL SCORE________**

Determine Fitzpatrick Skin Type Using the Following Table

Fitzpatrick Skin Type	I	II	III	IV	V/VI
Skin Type Total Score	0-7	8-16	17-24	25-30	> 30

Patient Signature: ____ Date: ______________________

Technician Signature:____ Date: ______________________

ELECTROLYSIS GENERAL INFORMATION

Print Name:____ Date:______________

Please Initial in Acknowledgement

____ I understand health history information is important in order to provide me with safe and effective treatments.

____ I acknowledge all information given by me is accurate to the best of my knowledge.

____ I agree to update my client profile whenever there are changes.

____ I know that hair removal will take a series of treatments to achieve satisfactory results.

____ I have been told that the success of my treatments will depend on my cooperation with my treatment schedule, my pain tolerance, inherited hair growth patterns, and any other instructions explained to me or recommended by the technician.

____ I have been advised of the post-treatment healing process, the possible risks related to treatment, and I agree to follow all after-care instructions given to me by the technician. I will notify the provider of the treatment of any difficulties in healing.

____ I understand and acknowledge that all deposits and payments for the above procedure are non-refundable unless I cancel my appointment at least two days prior to the procedure.

I acknowledge that all the information provided is to the best of my knowledge, and that it is important to keep this information up to date, especially medications, medical conditions and pregnancies, at each appointment.

I also acknowledge that I accept full responsibility for my care.

Patient Name (printed):_________________________________

Patient Signature: ____ Date: _____________________

Parent/Guardian Signature (if a minor): ________________________________ Date:_____________________

Technician Signature: ____ Date:_____ ________________

========================== FOR OFFICE USE ONLY ==========================

Initial electrolysis levels

Type of Hair: Terminal ____ Vellus ____ Accelerated Vellus ____ Treated Hair Color: _________________________________

Fitzpatrick Skin Type ______

Date: ____________ Test Area: __________________ Probe:________

CLIENT FORMULA

Thermolysis
Pico ____ s ____% ____x
Multi ____s ____ % / ____s ____ % ____ x
Melo ____s ____ % ____ x
Synchro ____s ____ % ____ x

Blend
Pico ____ s ____mA / ____s ____ % ____ x
Omni ____ s ____ mA / ____%
Multi ____ s ____ mA / ____% / ____ s ____ %
Evolu ____ s ____ mA / ____ %

Treatment Recommendation:

____
____
____

Technician's Name(Printed)___________________________ Immediate Results: ____________________________________.

LASER HAIR REMOVAL CONSENT

I, ____(print name), hereby authorize and direct the Certified Laser Specialist to perform laser hair removal on me using the Candela GentleLASE mini Laser/ Elos Motif.

The following points have been discussed with me:

- Laser hair removal works on the growing hairs and not the dormant hairs, thus the results are not a complete destruction of all the hair follicles and may require several treatments to completely remove hair.
- Laser hair removal is considered to be permanent hair reduction but can sometimes result in permanent hair removal. However, complete hair loss **may not** be experienced even with multiple laser treatments.
- The more contrast there is between the skin tone and hair color, the better the chances will be for the complete removal of the hair. Lesser contrast may result only in a reduction in the thickness of the hair.
- There is the possibility the laser can stimulate hairs with little or no pigment which can result in darker hair growth.
- Hormonal changes (puberty, menopause, pregnancy, hormone replacement therapy, etc.) and various medical conditions are some of the causes of superfluous hair growth.
- The laser will not work on most white, gray, blonde, and red hairs.
- The probability of success is dependent upon skin/hair color/contrast, pain tolerance of the patient, amount/thickness of hair being treated, and skin sensitivity.
- Hair re-growth rates vary on different areas of the body. Any new hair growth will not occur AT LEAST three weeks after the treatment. Treatment intervals vary depending on the area being treated. Upper body treatments can be performed at three- to six-week intervals and the lower body interval can be as long as two to three months.
- **DISCOMFORT** - Some discomfort may be experienced during laser treatment. A topical anesthetic may be used to help to reduce discomfort, but it is the client's responsibility to purchase and apply it prior to the treatment.
- **WOUND HEALING** - Laser treatment may result in blistering, crusting, or flaking of the area which may require 1-3 weeks to heal. Once the surface has healed, it may be pink and sensitive to the sun for an additional 2-4 weeks or longer.
- **SWELLING/INFECTION** - With some laser there may be some swelling noted, especially when the density of hair is strong. Skin infection is a possibility any time a skin procedure is performed.
- **PIGMENT CHANGES (Skin Color)** - During the healing stage, there is a possibility of the treated area becoming either lighter or darker than the surrounding skin. **This is usually temporary lastly between 3-24 months,** but, **on a rare occasion, it may be permanent**.
- **SCARRING** - Scarring is a rare occurrence, but it is a possibility when skin surface is disturbed. To minimize the chances of scarring, it is important that you follow all post-treatment instructions carefully.
- **EYE EXPOSURE** - Protective eyewear (shields) will be provided. **It is important to keep these shields on at all times during the procedure in order to protect your eyes from accidental laser exposure**.
- **AVOID** - (Following laser hair treatment) you must avoid tanning and skin irritants (Retin-A, alpha-hydroxy acids)

ACKNOWLEDGEMENT

- I agree to release the BUSINESS offering the laser treatment, the Licensed practitioner responsible for the treatment, and the Certified Laser Specialist/Laser Operator performing the treatment from liability associated with treatments using the Candela GentleLASE Plus Laser.
- **I agree to update my client profile, especially changes in tanning habits, medical conditions, and medications.**
- I understand that it is crucial to follow post-treatment procedures in order to prevent the chances of pigment changes, chances of scarring, or chances of changes in the skin texture of the treated area.

By my signature below, I certify that I have read and fully understand the contents of the Laser Hair Removal Consent form, that the disclosures referred to herein were made to me, and that I received a copy of the Before- and After-Care for Laser Hair Removal Instructions.

Patient Name (printed):___________________________________
Patient Signature: ____ Date: _____________________
Parent/Guardian Signature (if a minor): ___________________________________ Date:_____________________
Technician Signature: ____ Date: _____________________

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Initial Laser Levels

Type of Hair: Terminal ____ Vellus ____ Accelerated Vellus ____
Treated Hair Color: ________________________________

Laser Spot Test:
Fitzpatrick Skin Type ______
Date: ____________ Test Area: _________________ Spot Size: _______ Joules: _______ DCD: ____/____
Treatment Recommendation:
____
Technician's Name(Printed)___________________________ Immediate Results: ____________________________________.

Electrodessication Informed Consent

Print Name:____ Date:______________

I authorize **Senza Pelo MedSpa** to perform the procedure. The radio frequency(RF) treatment may dramatically reduce skin tags, milias, sebaceous hyperplasia, cholesterol deposits, mild Rosacea and small spider (telangiectasia)veins. More than one RF session may be necessary to achieve desired results. However, other treatments, including skin care products, are often needed to blend color, reduce sun damage, and give the best results. The skin treated may be red and swollen with fine, thin scabs. Keep the treated areas covered with Caladryl, Polysporin and Aquaphor until the thin scabs fall off. This process will take anywhere from 1-3 weeks. It could take as long as 1-3 months in some rare cases. Do not scratch the scabs, as that can cause scarring and prolong the healing time. *We are unable to treat clients that are on ACCUTANE. You must be off of Accutane for more than 6-months to resume treatment. Clients using ANTICOAGULANTS should be noted.*

The following problems may occur with treatment:

1. **Micro scarring:** The RF system can create a bruise and/or a moderate burn or blister to the skin. For an effective treatment, the RF energy needs to be just below the blistering point which means skin will be red. There is a slight risk of micro scarring.

2. **Hyper--pigmentation (browning) and Hypo--pigmentation (whitening):** have been noted after treatment, especially with a darker complexion. This usually resolves within weeks, but it can take as long as 1-3 months in some rare cases. Permanent color change is also a rare risk. If you have a lot of color in your skin, a skin lightening cream will be advised to reduce the melanin in your skin before the treatment. Avoiding sun exposure after the treatment is crucial to reduce the risk of color change.

3. **Infection:** Although infection following RF treatment is unusual, bacterial, fungal, and viral infections can occur if the area is picked or not kept clean. Herpes simplex virus infections around the mouth can occur following a RF treatment. Should any type of skin infection occur, additional treatment including antibiotics might be necessary. If you have a history of herpes simplex virus in the treated area we recommend preventative therapy.

4. **Bleeding:** Pinpoint bleeding is rare but can occur following RF treatment procedures. Should bleeding occur, additional treatment might be necessary.

5. **Skin tissue Pathology:** Energy directed at skin lesions may potentially vaporize the lesion. Only clearly benign pigmented lesions can be treated. Check with your dermatologist for clearance for the treatment if the lesion has changed in color, size, extremely elevated or is painful to the touch.

6. **Allergic reactions:** In rare cases, local allergies to tape, preservatives used in cosmetics or topical preparations, have been reported. Systemic reactions (which are more serious) may result from prescription medicines. Allergic reactions may require additional treatment.

Occasionally, unforeseen mechanical problems may occur and your appointment will need to be rescheduled. We will make every

ACKNOWLEDGMENT: My questions regarding the procedure have been answered satisfactorily. I understand the procedure and accept the risks. I hereby release the **Senza Pelo MedSpa & the RF Technician** from all liabilities associated with the above indicated procedure.

- I understand I may need multiple treatments for the desired outcome.
- Compliance with the aftercare guidelines is crucial for healing, prevention of scarring, hyper-pigmentation and hyperpigmentation.

Client/Guardian Signature____ Date ______________

RF Technician Signature ____ Date ______________