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:_____

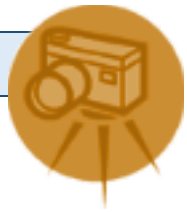
_____

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:_____

Release Form for Media Recording



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I, the undersigned, do hereby consent and agree that **Senza Pelo MedSpa**, its employees, or agents have the right to take photographs, videotape, or digital recordings of me beginning on _____, and ending on _____ and to use these in any and all media, now or hereafter known, and exclusively for the purpose of _____.
I further consent that my name and identity may be revealed therein or by descriptive text or commentary.

I do hereby release to **Senza Pelo MedSpa**, its agents, and employees all rights to exhibit this work in print and electronic form publicly or privately and to market and sell copies. I waive any rights, claims, or interest I may have to control the use of my identity or likeness in whatever media used.

I understand that there will be no financial or other remuneration for recording me, either for initial or subsequent transmission or playback.

I also understand that **Senza Pelo MedSpa** is not responsible for any expense or liability incurred as a result of my participation in this recording, including medical expenses due to any sickness or injury incurred as a result.

I represent that I am at least 18 years of age, have read and understand the foregoing statement, and am competent to execute this agreement.

_____
Name

_____
Address

_____
Phone

_____
Witness for the undersigned

_____
Signature Date