body hair gone

Client Information Form

Today's Date:	
CLIENT INFORMATION	
Last name:	First name:
Email:	Date of birth:
Mobile no.:	Alt. phone no.:
IN CASE OF EMERGENCY	
Name:	Relationship to you: / Mobile no.:

CLIENT HEALTH HISTORY		
Have you had Dermabrasion /Laser RX?	◯ Yes ◯ No	If yes, date and location of procedure.
Have you had any chemical peels (TCA, glycolic, etc.) in the last six months?	◯ Yes ◯ No	If yes, date and location of treatment.

WHICH HAIR REMOVAL METHODS HAVE YOU USED PRIOR TO TODAY? (CHECK ALL THAT APPLY)

TYPE	HOW OFTEN	OVER HOW LONG	DATE OF LATE TIME USED
Bleaching			
Tweezing			
Laser hair removal			
Waxing			
Threading/Sugaring			
Shaving/Cutting			
Depilatory (Nair)			
Electrolysis			

PREVIOUS ELECTROLOGY TREATMENTS:

Have you had previous electrology treatments?	◯ Yes ◯ No	How many?
When was your last electrology treatment?		
Did you have any skin reaction to your previous treatments?	◯ Yes ◯ No	If yes, please describe.

PLEASE LIST THE AREAS YOU WISH TO HAVE TREATED IN ORDER OF PRIORITY:

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

ADDITIONAL INFORMATION:

CLIENT HEALTH HISTORY, CONTINUED		
Do you have any allergies?	◯ Yes ◯ No	Which ones?
Are you currently under the care of a physician besides for wellness check-ups?	◯ Yes ◯ No	If yes, explain:
Any major surgeries?	◯ Yes ◯ No	If yes, please list.
Are you currently taking any medications (oral or otherwise)?	◯ Yes ◯ No	This includes hormones, birth control, diuretics, antidepressants, tranquilizers, etc. If yes, please list.
Are you taking any kind of blood thinning medications?	◯ Yes ◯ No	
Which topical medications do you use or have you used in the last 3 months (such as Retin-A, Hydroquinone, Hydrocortisone, topical antibiotics, fluorouracil, etc.)?		
Have you taken Accutane within the last 12 months?	◯ Yes ◯ No	
Heart problems?	◯ Yes ◯ No	If yes, which ones?
Seizures?	◯ Yes ◯ No	List medications.
Thyroid problems?	◯ Yes ◯ No	List medications.

PCOS?	◯ Yes ◯ No	Hormonal disorders?	◯ Yes ◯ No
Kidney/Adrenal problems?	◯ Yes ◯ No	Hepatitis?	◯ Yes ◯ No
HIV/Aids?	◯ Yes ◯ No	Herpes I/II (cold sore/genital)	◯ Yes ◯ No

HEALTH HISTORY QUESTIONS FOR WOMEN ONLY:

Do you have regular periods?	◯ Yes ◯ No	Are you going through perimenopause?	◯ Yes ◯ No
Are you going through menopause?	◯ Yes ◯ No	Are you pregnant?	◯ Yes ◯ No
Are you trying to become pregnant?	◯ Yes ◯ No	Hyperpigmentation during pregnancy?	◯ Yes ◯ No
Pigment change due to hormone meds?	◯ Yes ◯ No	Do you have an IUD	◯ Yes ◯ No

READ STATEMENTS AND INITIAL TO THE RIGHT IF YOU ARE IN AGREEMENT (TO BE COMPLETED IN OFFICE.)

I have been cautioned about the histaminic reaction to treatment. _____

I have been instructed to shave specific areas to be treated. _____

I have been cautioned about use of makeup, astringents and exposure to sun. _____

I have been cautioned that cold sores/fever blisters will be aggravated by treatment and that treatment will not be given in any area where there is an active cold sore or fever blister. _____

I understand that a series of stripping and maintenance treatments will be necessary to effect permanent removal of hair in each area I select to have treated. Treatment will be limited to hairs in the anagen (active) stage of the hair's natural cycle, in each area I elect to have treated. The schedule of treatment is dictated by the natural cycle of the hair in each area. _____

CLIENT MUST READ AND INDICATE THEIR UNDERSTANDING BY SIGNING - ELECTROLYSIS IS A SEMI-INVASIVE PROCEDURE WHICH MAY AGGRAVATE CERTAIN DISORDERS. WE MAY REQUIRE PERMISSION AND A RELEASE FORM FROM YOUR PHYSICIAN BEFORE WE BEGIN TREATMENT.

_____ _____

Client Signature Date