



CLIENT INFORMATION/MEDICAL HISTORY

Name _____ Age _____ Date _____

Address _____ City _____ State _____ Zip _____

Email Address _____

Cell _____ Date of Birth _____

Emergency Contact _____ Relationship _____ Cell _____

Medications (Prescriptions/over the counter med, vitamins, herbal medications)

Drug Allergies _____

Major Surgeries/Facial surgeries _____

Ongoing facial treatments? (Injectibles/Laser/chemical peels/waxing/facials) _____

Please circle if you have any of the following conditions -

Heart Disease Excessive Bleeding High Blood Pressure Hepatitis Skin Cancer Liver Disease

Lupus Auto-Immune Disorders Diabetes Neuromuscular Disease Cold Sores/Fever Blisters

Lidocaine allergy/sensitivity

Pregnant? Y N Breastfeeding? Y N

The above information is true and accurate to the best of my knowledge.

Client Signature

Date



CHEMICAL PEEL CONSENT FORM

Name _____ Date _____

I authorize _____ to perform the following chemical peel treatment:

_____.

I understand if any of the following conditions apply at this time, I am unable to receive the chemical peel stated above.

- Allergy to Aspirin or any salicylic sensitivity
- Allergy to apples, citrus, cosmetics, iodine, latex, or milk
- Use of Accutane within the past 12 months
- Use of Retin-A, Renova, Retinol or any other Vitamin A derivative products in the last 3 days
- Use of glycolic acid products in the last 3 days
- Broken skin in areas to be treated
- Sunburn or windburn skin
- Visible inflammatory or inflammatory lesions
- Recent peels within 14 days

I understand the results will vary between individuals and no guarantees have been made regarding my personal results, level of discomfort or the degree/duration of peeling/flaking. **Initial** _____

I consent to the taking of photographs and authorize their anonymous use for the purposes of clinical audit, education and promotion. **Initial** _____

I understand that to maximize the results, I should receive a series of peels. I have received the pre- and post-treatment instructions and understand that compliance will help determine the level of success and outcome of the treatment. **Initial** _____

I have been informed and understand the contraindication to the requested treatments and agree that I do not have any condition(s) that would make the requested treatment unsuitable. I will inform the technician of any discomfort I may experience at any time during my treatment to allow them to adjust accordingly. **Initial** _____

The procedure and side effects have been explained to me and I have had the opportunity to ask questions. My questions have been answered in a satisfactory manner. **Initial** _____

I agree to waive all liabilities toward my technician and the employer for any injury or damages incurred. I accept all risk and liability for this cosmetic procedure. This form is valid for future treatments until it is rescinded by me in writing. **Initial** _____

Client Signature (Guardian if under 18)

Date