



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

DERMAPLANING

CONSENT FORM

[dûr'-mə-plān-ing] verb



a mechanical form of exfoliation using a specialized blade for the removal of built up dead skin cells and vellous hair.

I _____ give my consent to receive Dermaplaning treatments.

Are you affected by or have any of the following?

- | | |
|--|--|
| <input type="checkbox"/> Pregnant/Lactating | <input type="checkbox"/> Skin Disease/Infection |
| <input type="checkbox"/> Tanning by Booth or Sun | <input type="checkbox"/> Recent Chemical Peels |
| <input type="checkbox"/> Accutane | <input type="checkbox"/> Permanent Makeup |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Immune Disorders |
| <input type="checkbox"/> Rosacea | <input type="checkbox"/> Heart Condition/Pacemaker |
| <input type="checkbox"/> Skin Cancer | <input type="checkbox"/> Chemotherapy/Radiation |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Hemophilia/Blood Thinners |
| <input type="checkbox"/> Recent waxing of the area | <input type="checkbox"/> Telangiectasia |
| <input type="checkbox"/> Botox/Fillers- Last treatment _____ | |
| <input type="checkbox"/> Other Medical Conditions _____ | |

By signing below, you agree to the following:

I understand that results will vary between individuals and no guarantees have been made regarding my personal results. I understand that my results may be compromised if I do not follow the aftercare instructions that I have been given. I agree to have photographs taken to monitor the effects of the treatment.

I understand that to achieve the maximum benefit a series of treatments is necessary.

I have been informed of and understand the contraindications 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.

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.

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 consent form is valid for future treatments until it is rescinded by me in writing.

Have you ever had an allergic reaction to any of the following?

- | | |
|------------------------------------|-------------------------------------|
| <input type="checkbox"/> Food | <input type="checkbox"/> Cosmetics |
| <input type="checkbox"/> Glycerine | <input type="checkbox"/> Synthetics |
| <input type="checkbox"/> Medicine | <input type="checkbox"/> Metals |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Aspirin |

Other _____

Do you currently or have you in the last week used Renova, Retin-A, AHA's, Retinol or any other Vitamin A derivative products? If yes, please explain

I understand that the following are potential side effects that typically resolve within 3 days:

- | | |
|------------------------|-------------|
| Redness | Abrasions |
| Irritation | Sensitivity |
| Cuts/Scapes | Peeling |
| Fever Blister Flare up | Dryness |

Current Medications (including topical and OTC):

Client Signature (Guardian if under 18)

Date _____

