Refine Aesthetics

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

I _____ give my consent to receive Dermaplaning treatments.

Are you affected by or have any of the following?

- ☐ Pregnant/Lactating
- ☐ Tanning by Booth or Sun
- ☐ Accutane
- ☐ Diabetes
- ☐ Rosacea
- ☐ Skin Cancer
- ☐ Cold Sores
- ☐ Recent waxing of the area
- ☐ Skin Disease/Infection
- ☐ Recent Chemical Peels
- ☐ Permanent Makeup
- ☐ Immune Disorders
- ☐ Heart Condition/Pacemaker
- ☐ Chemotherapy/Radiation
- ☐ Hemophilia/Blood Thinners
- ☐ Telangiectasia

☐ Botox/Fillers- Last treatment _____

☐ 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.

_____

Client Signature (Guardian if under 18)

Date _____

[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.

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

- ☐ Food
- ☐ Glycerine
- ☐ Medicine
- ☐ Latex
- ☐ Cosmetics
- ☐ Synthetics
- ☐ Metals
- ☐ Asprin

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 winthin 3 days:

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

Current Medications (including topical and OTC):

_____

_____

_____

_____

CONSENT FOR A ENZYME TREATMENT

I, _____, give permission to my skin care professional to perform an enzyme treatment.

1. I agree to complete a Skin Consultation. I agree to complete and be truthful about my physical conditions, pregnancy, medications that I may be taking, and my current skin care regimen. I am also aware that my lifestyle, which if it includes smoking, outdoor exposure, tanning beds, excessive alcohol will effect and diminish the effectiveness and result of the treatment.

2. I have disclosed to the service provider any surgical procedures, laser treatments, or facial procedures that I have had.

3. I am not presently pregnant or lactating

4. I have not had any recent chemotherapy or radiation treatments

5. I have not recently waxed on the area being treated today. I do not have a history of keloid scarring, diabetes, any autoimmune disease, active herpes blisters or cold sores.

6. I will refrain from excessive sun exposure and the use of a tanning bed while I am undergoing treatment.

7. I have disclosed to my skin care professional any treatments of any kind that I have received within 14 days.

8. I understand that although complications are very rare, sometimes they may occur and that prompt treatment is necessary.

9. I understand that the following conditions preclude me from having this treatment at this time and verify that none of these conditions apply to me at this time.

Allergic to citric fruits (oranges, limes, grapefruit, lemons)

Allergic to pineapple and/or papaya

Allergic to cocoa, chocolate, and/or raspberry

History of being