natural look now LLC

CLIENT INFORMATION AND SKIN CARE PROFILE

THIS INFORMATION IS COMPLETELY CONFIDENTIAL AND WILL BE USED FOR THIS ANALYSIS ONLY

Date____/____/_____

Client Name_____ Age _____ Birthday_____/_____/_____

Address_____ City_____ State_____ Zip_____

Cell_____ Home_____ Email _____

Occupation_____ Employer_____

Preferred Appointment Day: Mon.□ Tues.□ Wed.□ Thurs.□ Fri.□ Sat.□ Time: Morning □ Mid-Day □ Afternoon □

Confirmation Preference (note: we default to email if one is not chosen): Text □ Cell Phone □ Home Phone □ Email □

Referred By: _____

Allergies: _____

Current Medications: _____

Other/Explain: _____

LIFESTYLE

Daily Consumption: Water_____ oz's Coffee_____cups Soft Drinks_____oz's Alcohol? Yes □ No □

PERSONAL SKIN CARE

Soap □ Cleanser □ Toner □ Moisturizer □ Masque □ Scrub □ _____

FEMALE CLIENTS ONLY

Are you currently taking oral contraception? Yes □ No □

Are you currently pregnant or trying to become pregnant? Yes □ No □

MALE CLIENTS ONLY

Shaving System? Wet □ Dry □ Ingrown Hairs? Yes □ No □

Medical

Health Problems: Cancer □ Diabetes □ Thyroid □ Hysterectomy □ Hormone Imbalance □

1	Yes	No	Are you under a physician's care for any medical condition at this time?	23	Yes	No	Have you ever had cold sores?
2	Yes	No	Are you pregnant or nursing?	24	Yes	No	Do you have any type of herpes?
3	Yes	No	Do you have eczema?	25	Yes	No	Do you wear contact lenses?
4	Yes	No	Do you have psoriasis	26	Yes	No	Do you wear glasses?
5	Yes	No	Do you have hemophilia?	27	Yes	No	Do you have glaucoma?
6	Yes	No	Do you have acne?	28	Yes	No	Do you have dry eye syndrome?
7	Yes	No	Do you have skin cancer?	29	Yes	No	Do you have blocked tear ducts?
8	Yes	No	Do you have vitiligo?	30	Yes	No	Do you have allergies to latex?
9	Yes	No	Do you have rosacea?	31	Yes	No	Do you bruise easily?
10	Yes	No	Do you have dermatitis?	32	Yes	No	Do you have any problems healing from minor wounds?
11	Yes	No	Do you hyperpigment when you scar?	33	Yes	No	Do you tend to develop keloid or hypertrophy scars?
12	Yes	No	Do you hypopigment when you scar?	34	Yes	No	Do you have a tendency to faint or become dizzy?
13	Yes	No	Have you had plastic surgery?	35	Yes	No	Are you undergoing radiation or chemo-therapy treatment?
14	Yes	No	Are you contemplating plastic surgery?	36	Yes	No	Are you sensitive to petroleum based products?
15	Yes	No	Do you have high blood pressure?	37	Yes	No	Are you now, or have you ever been on the acne treatment Accutane?
16	Yes	No	Do you have low blood pressure?	38	Yes	No	Are you under treatment for depression?
17	Yes	No	Do you have asthma?	39	Yes	No	Do you take prescription drugs?
18	Yes	No	Do you have any type of heart disease?	40	Yes	No	Do you intentionally tan- direct sun or tanning bed?
19	Yes	No	Do you wear a pace maker?	41	Yes	No	If you tan, do you burn easily?
20	Yes	No	Do you have any medical implants?	42	Yes	No	Do you have a history of stroke or heart attack?
21	Yes	No	Do you have diabetes or any auto-immune disorders?	43	Yes	No	Do you take any herbal supplements?
22	Yes	No	Do you have any seizure related condition?	44	Yes	No	Do you have any problems being anesthetized for dental procedures?

Consent Form

Read this consent form thoroughly and initial each section as needed. Discuss any questions with your skin care professional before you initial. Your signature and date at the bottom constitutes giving your consent to the initialed treatments and procedures.

I _____ give my consent for the following procedure(s):

Massage consent: _____

I have notified the technician of any resent muscle or back injuries and understand the possible complications of massage therapy.
Massage Preference: Firm □ Light □ Preferred Area of Focus: _____

Skin Care Treatment consent: _____

I have notified the skin care professional of any previous or current skin disorders or blemishes. I understand the possible complications and consent to the following skin care procedure(s).

Waxing consent: _____

I have advised my waxing specialist of any of the following: cuts or abrasions, inflammation, open wounds, suspicious growths, active herpes, hemophilia, use of Accutane, use of Retin-A, use of AHA's, recent infections, diabetes, or phlebitis.

Have you ever had any adverse reactions to waxing? _____

I understand that following the waxing procedure, I should: apply a sunblock with an SPF of at least 15, avoid the use of a loofah or other abrasives to the waxed area, avoid saunas, steam rooms, Jacuzzis, or other heat sources, and avoid application of Retin-A or an AHA product for 48 hours. Please note that you may be more sensitive to the waxing procedure if you are premenstrual or taking antibiotics.

Lash Enhancements consent: _____

I understand that the glue has a 2 second dry time and is best used in dryer climates. The adhesive does have more fumes that can cause some irritation at time of application. It does not contain formaldehyde or latex, and is very compatible for people with sensitive skin. The adhesion time has a 5-6 week bonding time. The longevity is best if after care instructions are followed to avoid losing your lashes. If you choose to maintain the lash extensions, you must come in every 3 weeks to maintain care or have the technician properly remove them.

Dermaplaning consent: _____

I understand there are contraindications to this treatment, including but not limited to, diabetes, cancer, active acne, bleeding disorders and the inability for blood to coagulate following injury. Certain medications including blood thinners such as Coumadin, Warfarin, Heparin, Plavix, and/or Aspirin, and Accutane are contraindicated for this treatment due to the possibility of excessive bleeding from a nick or cut. I certify that I am not taking any of the above medications or experiencing any of the above conditions. I understand this treatment involves the use of the sterile, surgical blade to remove dead skin cells and villous hair. As with the use of any sharp instrument, there is the possibility of nicks or cuts. While every precaution is taken I understand the risks and consent to the treatment.

I have completed the client medical form accurately: _____

I have completed the skin type test: _____

I understand that there are no guaranteed results from any treatments. Many variables such as age, sun damage, ongoing sun exposure, smoking, excessive alcohol intake, climate, diet, water intake, skin thickness, and sensitivity can affect the results of all treatments. I have been candid in revealing any condition that could prohibit any treatment such as cold sores, pregnancy, and use of hormones (birth control or HRT), recent facial surgery or laser resurfacing, recent use of Retin-A, or use of Accutane within the last 6 months. Any immune system diseases including but not limited to Lupus, HIV, or diabetes can affect the healing time of certain procedures. Regardless of precautions taken, I acknowledge the possibility of an adverse reaction to treatments and accept sole responsibility for any medical care that may become necessary. I will immediately notify the doctor, nurse, or esthetician performing the treatment of any adverse reactions. I will not scratch, pick, pull at, or abrade the treated skin. I understand that direct sun exposure and use of a tanning booth is prohibited during dermaplaning and chemical peel treatments for 14 days post peel, or the amount of time discussed by the aesthetician. I will comply with the mandatory use of a minimum SPF 15 sun protection daily. I have not received any other peels or exfoliation treatments of any kind within 14 days of this treatment. I understand that to achieve maximum results the recommended home care routine must be followed. I understand that if I alter the routine or use products not recommended by the skin care professional the results could be altered or inhibited. I also understand that it may take several treatments to obtain the desired results. I understand that the following side effects or complications can occur: discomfort, redness and swelling, hypopigmentation, itching or irritation, skin peeling or flaking up to 14 days after the procedure, infection, scarring, hyperpigmentation, and/or acne breakouts. I understand the goals of the treatment about to be received as well as the limitations and possible complications. The technician has provided the information and has answered all my questions concerning this procedure. I clearly understand the above information.

Cancellation Policy

We understand that sometimes life happens but we do request a 24 hour notice of cancellation if you must cancel your appointment so that we have time to schedule another client as we have reserved this time for you. No Shows will be charged 100% for the service reserved. A minimum of $50 will be charged at the discretion of management. Last minute cancellations will be charged 50 % for the service reserved. If the service time can be filled by another client, you will not be charged.

Client Signature_____ **Date** _____

Parent/Guardian Signature*_____ **Date** _____

*for clients under the age of 18

Physician/Technician Signature _____ **Date** _____