Aesthetics & Electrology - Seattle
Confidential Client Intake and Consent for Treatment

Name: ____

Address: ____

Occupation: ____________________________________ DOB: _______/_________/_________

Email: ___________________________@_______________ Phone:_____________________________

***I wish to be reminded of appoints by**: Email Phone Text (Cell:________________________)

Emergency Contact: _________________________________ Phone: ___________________________

Referred by: _______________________________________

List any allergies:

____

List any medications or supplements (aspirin, etc.) you're currently taking, topical or oral:

____

____

Have you ever had LASER skin rejuvenation or hair removal? Y N If so, when?_________________

Health Issues (some, but not all of these issues may be contraindications for treatment):

Bleeding Disorder	Y	N	Cancer*	Y	N	Diabetes*	Y	N
Epilepsy/Seizures	Y	N	Herpres	Y	N	HIV/AIDS	Y	N
Pigmentation Disorder	Y	N	Liver Disease	Y	N	Heart Disease	Y	N
High Blood Pressure*	Y	N	Pacemaker*	Y	N	Pregnancy	Y	N

* These health issues must be under control or have a physician's/manufacturer's approval before treatment.

Skin Conditions::

☐ Acne/Blackheads/Milia	☐ Rosacea	☐ Hyperpigmentation	☐ Loss of tone/firmness
☐ Fine Line	☐ Wrinkles	☐ Eczema	☐ Rosacea
☐ Keloid Scars	☐ Psoriasis	☐ Seborrheic Dermatitis	☐ Erysipelas (red skin)
☐ Botox (30 days)	☐ Filler (30 days)	☐ Lesions	☐ Accutane

Have you ever had a facial? Y N If so, when was your last facial? __________________

Have you ever had a chemical peel? Y N If so, when was your last peel? ___________________

<u>Please continue on back</u>

Skin Care Products:

List cleanser(s), moisturizers, exfoliants, acne, anti-aging, and natural skin care products:
____

____

____

For Electrolysis Clients

Excess hair location: ____

Aesthetics & Electrology - Seattle

Consent for Treatment

Please read carefully and sign where indicated

I understand and have read the questionnaire on the reverse side of this consent and answered all questions truthfully. I agree this constitutes full disclosure, and this Consent for Treatment supersedes any previous verbal or written disclosures. I further understand that signing this Consent for Treatment does not constitute a contract for treatment.

I understand that withholding information or providing misinformation may result in scarring, unnecessary inflammation, hyperpigmentation, hypopigmentation and other negative reactions in the area treatmented. I am aware it is my responsibility to inform Aesthetics & Electrology of my current medical and health conditions and to update my history and skin care regimine as changes occur.

I agree to follow before and after care instructions..

I agree to contact Aesthetics and Electrology with any concerns following my treatment.

The treatment I receive is voluntary and I release Aesthetics & Electrology and the skin care professional performing my treatment and the Medical Dental Building management from liability and assume full responsibility thereof, except where expressly excluded by law.

SIGNATURE OF PATIENT (OR PARENT/GUARDING, IF UNDER 18):

____ DATE: ____________________________

For Office Use Only:

Date	Minutes	Area Treated	RF	DC	Size	Notes