Skinology Skincare's Client Health Questionnaire

Date / /

9159 W 133rd street, Overland Park, KS 66213 # 913.239.8501

Client Information:

Name _____
Home Phone_____ Cell Phone_____ Email _____
Address_____City_____State _____ Zip_____
Single___ Married___ Spouse's Name_____ Children's Name_____
Date of birth _____/_____/_____ Occupation_____
Referred by_____
Additional Information

Medical Information: check all that apply

☐ Pregnant	☐ Birth Control	☐ Hormone Replacement	☐ Smoker
☐ Oral Antibiotic	☐ Topical Antibiotic	☐ Steroids	☐ Asthma
☐ Neck / Back Pain	☐ Headaches	☐ Migraines	☐ Seasonal Allergies
☐ Latex Allergy	☐ Peanut Allergy	☐ Iodine Allergy	☐ Aspirin Allergy
☐ Hypertension*	☐ Heart Disease**	☐ Pacemaker**	☐ Metal Plates, Pins, or Prosthetics
☐ Diabetic	☐ Prone to Cold Sores	☐ Epilepsy	☐ Herpes
☐ Rashes/ Hives	☐ Shingles	☐ Bursitis	☐ Skin Cancer
☐ Rosacea	☐Use Retinol	☐ Use Tazorac	☐ Use Accutane: last used ___/___/____

☐ Currently under physician's Care: _____

Daily Home Regimen: check all that apply

☐ Facial Soap	☐ Facial Cleanser	☐ Toner	☐ Moisturizer
☐ Masque	☐ Exfoliator / Scrubs	☐ Eye Product	Brands_____
☐ Sunscreen Daily	☐ Sunscreen Recreationally		☐ Tan/ Tanning Beds

Are you currently using any products that contain the following ingredients?

☐ Glycolic Acid	☐ Lactic acid	☐ Hydroxy Acid	☐ Vitamin A Derivatives

Skin Concerns: check all that apply

☐ Premature Aging	☐ Sun Damage	☐ Wrinkles	☐ Texture/Tone
☐ Pigmentation	☐ Acne	☐ Flushing / Redness	☐ Pore Size

When you go out into the sun do you:		☐ Always Burn (I)	☐ Usually Burn (II)
☐ Sometimes Burn (III)	☐ Rarely Burn (IV)	☐ Very Rarely Burn (V)	☐ Never Burns (VI)

I understand that the use of certain medications and over the counter products can significantly increase the risk of adverse reactions and/or injury. I hereby confirm that I am not using any medication that may cause or contribute to any such reaction/injury and I will advise my therapist should I being using any such medication in the future. I understand that there are inherent risks associated with skincare services, and I agree that as a condition of providing these services on an ongoing basis, I will not hold responsible anyone at **Skinology Skincare, LLC** should there be any unfavorable outcome or result.

Client Signature _____ Date _____/_____/_____

Skinology Skincare's **Client Consent to Treatment**

My signature acknowledges that I have read and agree to receive the following treatments or series of treatments.
I,____ consent to and authorize **Skinology Skincare, LLC** to perform facials, skin exfoliation, chemical peels, microdermabrasion, micro current, skin waxing and other related skin care services.

- **I have not used Accutane for at least 12 months.** ______________(Initial)
- **I have not used a scrub, Retin-A, Tazorac, take home microdermabrasion, glycolic peels or other types of exfoliates in the last 72 hours.** ______________(Initial)
- I have no allergies to Iodine (seaweed/algae based). ______________(Initial)
- I have no allergies to peanuts. ______________(Initial)
- I have no allergies to aspirin. ______________(Initial)
- I am not Epileptic and do not have heart or circulation problems. ______________(Initial)
- **Possible side effects** from microdermabrasion, chemical peels, and micro currents, but are not limited to: mild redness, extreme redness, bruising, local swelling, stinging, tenderness, dry skin, flaking, lightening or darkening of the skin, infections, pimples, bumpy appearance, and cold sores. **Most side effects are temporary and generally fade within 72 hours.** ______________(Initial)
- **Waxing may cause**: bruises, scabs, scarring, redness, hyper pigmentation or pimples. Waxing of soft tissue may cause the skin to tear resulting in the need for stitches (Brazilian/Bikini). ______________(Initial)
- I agree not to pick, peel, or scratch the skin during the healing phase, as this may cause undesirable side effects or results. ______________(Initial)
  It is recommended to discontinue use of all AHA's, Glycolic, Retin-A, Renova, or any exfoliation products up to 72 hours post procedure. ______________ (Initial)
- **I agree to use Image Post-Treatment Kits as directed or products in the Vital-C or OrMedic Skincare line and Solar Defense daily.** ______________(Initial)
- **Use hydrocortisone crème twice a day as needed** with a cold compress for swelling and inflammation reduction. ______________ (Initial)
- **Use Vanish PFB twice a day** for a week after any wax services to prevent ingrown hairs and break outs; and use as needed after. ______________ (Initial)
- After treatments **avoid, direct sun exposure, tanning beds, pools, hot tubs, saunas, waxing, and additional professional treatments for 72 hours.** ______________(Initial)
- If I have Herpes or MRSA I may experience an outbreak and I understand I may carry Herpes and/or MRSA without any physical symptoms or having had a medical diagnosis confirmed. ______________(Initial)
- If prone to cold sores see your physician about a prescription for Aycloovair, Zovirax, or take supplements of Olive Leaf, L-Lysine along with Beta Carotene, and Folic Acid daily. ______________(Initial)
- The nature and purpose of the treatments have been explained to me, and any questions I may have regarding this procedure have been explained to my satisfaction. ______________(Initial)
- I understand that with any treatment certain risks are involved and that any complications or side effects from known or un-known causes could occur. I freely assume these risks. ______________(Initial)
- **I have received a Copy of Client Consent of Treatment**. ______________(Initial)

Client Signature____ Date _____/______/_________

Additional Treatment Consent:

Date ___/__/___ Initials ____________	Date ___/__/___ Initials ____________	Date ___/__/___ Initials ____________
Date ___/__/___ Initials ____________	Date ___/__/___ Initials ____________	Date ___/__/___ Initials ____________
Date ___/__/___ Initials ____________	Date ___/__/___ Initials ____________	Date ___/__/___ Initials ____________
Date ___/__/___ Initials ____________	Date ___/__/___ Initials ____________	Date ___/__/___ Initials ____________
Date ___/__/___ Initials ____________	Date ___/__/___ Initials ____________	Date ___/__/___ Initials ____________
Date ___/__/___ Initials ____________	Date ___/__/___ Initials ____________	Date ___/__/___ Initials ____________
Date ___/__/___ Initials ____________	Date ___/__/___ Initials ____________	Date ___/__/___ Initials ____________
Date ___/__/___ Initials ____________	Date ___/__/___ Initials ____________	Date ___/__/___ Initials ____________
Date ___/__/___ Initials ____________	Date ___/__/___ Initials ____________	Date ___/__/___ Initials ____________
Date ___/__/___ Initials ____________	Date ___/__/___ Initials ____________	Date ___/__/___ Initials ____________

Skinology Skincare's Client Consent to Treatment

9159 W 133rd Street, Overland Park, KS #913.239.8501

Client Copy

My signature acknowledges that I have read and agree to receive the following treatments or series of treatments. I,_____ consent to and authorize **Skinology Skincare, LLC** to perform facials, skin exfoliation, chemical peels, microdermabrasion, micro current, skin waxing and other related skin care services.

- **I have not used Accutane for at least 12 months.** _____(Initial)
- **I have not used a scrub, Retin-A, Tazorac, take home microdermabrasion, glycolic peels or other types of exfoliates in the last 72 hours.** _____(Initial)
- I have no allergies to Iodine (seaweed/algae based). _____(Initial)
- I have no allergies to peanuts. _____(Initial)
- I have no allergies to aspirin. _____(Initial)
- I am not Epileptic and do not have heart or circulation problems. _____(Initial)
- **Possible side effects** from microdermabrasion, chemical peels, and micro currents, but are not limited to: mild redness, extreme redness, bruising, local swelling, stinging, tenderness, dry skin, flaking, lightening or darkening of the skin, infections, pimples, bumpy appearance, and cold sores. **Most side effects are temporary and generally fade within 72 hours.** _____(Initial)
- **Waxing may cause**: bruises, scabs, scarring, redness, hyper pigmentation or pimples. Waxing of soft tissue may cause the skin to tear resulting in the need for stitches (Brazilian/Bikini). _____(Initial)
- I agree not to pick, peel, or scratch the skin during the healing phase, as this may cause undesirable side effects or results. _____(Initial)
  It is recommended to discontinue use of all AHA's, Glycolic, Retin-A, Renova, or any exfoliation products up to 72 hours post procedure. _____ (Initial)
- **I agree to use Image Post-Treatment Kits as directed or products in the Vital-C or OrMedic Skincare line and Solar Defense daily.** _____(Initial)
- **Use hydrocortisone crème twice a day as needed** with a cold compress for swelling and inflammation reduction. _____ (Initial)
- **Use Vanish PFB twice a day** for a week after any wax services to prevent ingrown hairs and break outs; and use as needed after. _____ (Initial)
- After treatments **avoid, direct sun exposure, tanning beds, pools, hot tubs, saunas, waxing, and additional professional treatments for 72 hours.** _____(Initial)
- If I have Herpes or MRSA I may experience an outbreak and I understand I may carry Herpes and/or MRSA without any physical symptoms or having had a medical diagnosis confirmed. _____(Initial)
- If prone to cold sores see your physician about a prescription for Aycloovair, Zovirax, or take supplements of Olive Leaf, L-Lysine along with Beta Carotene, and Folic Acid daily. _____(Initial)
- The nature and purpose of the treatments have been explained to me, and any questions I may have regarding this procedure have been explained to my satisfaction. _____(Initial)
- I understand that with any treatment certain risks are involved and that any complications or side effects from known or un-known causes could occur. I freely assume these risks. _____(Initial)

Client Signature_____ Date _____/_____/_____