**CLIENT INFORMATION & MEDICAL HISTORY**

*In order to provide you with the most appropriate laser treatment, we need you to complete the following*

*questionnaire. All information is strictly confidential.*

**PERSONAL HISTORY**

Client Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date \_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_\_

Home Phone ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name and Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How were you referred to us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which of the following best describes your skin type? (Please circle one type number)

I Always burns, never tans

II Always burns, sometimes tans

Ill Sometimes burns, always tans

IV Rarely burns, always tans

V Brown, moderately pigmented skin

VI Black skin

**MEDICAL HISTORY:**

Are you currently under the care of a physician or dermatologist? Yes No

If yes, for what:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a history of erythema abigne, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation? Yes No

Do you have any of the following medical conditions? (Please check all that apply)

\_\_\_\_\_Cancer, \_\_\_\_\_Diabetes, \_\_\_\_\_High blood pressure, \_\_\_\_\_Herpes, \_\_\_\_\_Arthritis, \_\_\_\_\_Frequent cold sores, \_\_\_\_\_HlV/AIDS, \_\_\_\_\_Keloid scarring, \_\_\_\_\_Skin disease/Ski lesions, \_\_\_\_\_Seizure disorder, \_\_\_\_\_Hepatitis, \_\_\_\_\_Hormone imbalance, \_\_\_\_\_Thyroid imbalance, \_\_\_\_\_Blood clotting abnormalities, \_\_\_\_\_Any active infection

Do you have any other health problems or medical conditions? Please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had an allergic reaction to any of the following? (Please check all that apply and describe the reaction you experienced): \_\_\_Food, \_\_\_Latex, \_\_\_Aspirin, \_\_\_Lidocaine, \_\_\_Hydrocortisone, \_\_\_\_\_Hydroquinone or skin bleaching agents, Others: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATIONS**

What oral medications are you presently taking? \_\_\_\_\_ Birth control pills, \_\_\_\_\_ Hormones, Others (Please list): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you on any mood altering or anti-depression medication? Yes No

Have you ever used Acutane? Yes No If yes, when did you last Use it?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What topical medications or creams are you currently using? \_\_\_\_\_ RetinA, Others (Please list): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What herbal supplements do you Use regularly? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever received Gold Therapy? Yes No

**HISTORY**

Have you ever had laser hair removal? Yes No

Have you used any of the following hair removal methods in the past SIX Weeks?

\_\_\_\_Shaving \_\_\_\_\_\_UV\tanning \_\_\_\_\_Electrolysis \_\_\_\_\_Plucking \_\_\_\_\_Tweezing \_\_\_\_\_Stringing \_\_\_\_\_\_Depilatories

Have you had any recent tanning or sun exposure that changed the color of your skin? Yes No

Have you recently used any self-tanning lotions or treatments? Yes No

Do you form thick or raised scars from cuts or burns? Yes No

Do you have Hyperpigrnentation (darkening of the skin) or Hypopigmentation

(lightening of the skin) or marks after physical trauma? Yes No

Do you have pacemaker or any metal plates/braces? Yes No

 If you answered yes to any of the above 5 questions, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FOR FEMALE CLIENTS:**

Are you pregnant or trying to become pregnant? Yes No Are you breastfeeding? Yes No

Are you using contraception? Yes No

*I certify that the preceding medical, personal and skin history statements are true and correct I am aware that it is my responsibility to inform the technician esthetician, therapist doctor or nurse of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures*

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Informed Consent for Hair Removal**

Customer’s name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treatment sites: mono-brow, lip, chin, neck, face, arms, fingers, chest, areola, stomach, underarms, back, buttocks, bikini, labia, scrotum, thighs, lower legs, feet and toes. Combinations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous hair removal methods: shaving, tweezing, waxing, depilatories, electrolysis, laser.

The purpose of this procedure is to diminish or remove unwanted hair. The procedure requires more than one treatment and may produce permanent hair removal. The total number of treatments will vary between individuals. On rare occasion there are patients that do not respond to treatments. The treated hair should exfoliate or push out in approximately 2-3 weeks.

Alternative methods are waxing, shaving, electrolysis, and chemical epilation.

The following problems may occur with the hair removal system:

I. However slight, there is a risk of scarring.

2. Short term effects may include reddening, mild burning, temporary bruising or blistering. Hyper-pigmentation (browning) and hypo-pigmentation (lightening) have also been noted after treatment. These Conditions usually resolve within 2 weeks - 6 months, but permanent color change is a rare risk. Avoiding sun exposure before and after the treatment reduces the risk of color change.

3. Infection: Although infection following treatment is unusual, bacterial, fungal and viral infections can occur. Herpes simplex virus infections around the mouth can occur following a treatment. This applies to both individuals with a past history of herpes simplex virus infections and individuals with no known history of herpes simplex virus infections in the mouth area. Should any type of skin infection occur, additional treatments or medical antibiotics may be necessary.

4. Bleeding: Pinpoint bleeding is rare but can occur following treatment procedures. Should bleeding occur, additional treatment may be necessary.

5. Allergic Reactions: In rare cases, local allergies to tape, preservatives used in cosmetics or topical preparations have been reported. Systemic reactions (which are more serious) may result from prescription medicines.

6. I understand that exposure of my eyes to light could harm my vision. I must keep the eye protection goggles on at all times.

7. Compliance with the aftercare guidelines is crucial for healing, prevention of scarring, and hyper-pigmentation.

Occasionally, unforeseen mechanical problems may occur and your appointment will need to be rescheduled. We will make every effort to notify you prior to your arrival to the office. Please be understanding if we cause you any inconvenience.

ACKNOWLEDGMENT: My questions regarding the procedure have been answered satisfactorily. I understand the procedure and accept the risks. I hereby release \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (individual) and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (facility) from all liabilities associated with the above indicated procedure. I hereby grant SereneMax LLC permission to use my likeness, without compensation, in print, video or any digital form, for the purposes of education, communication or marketing. I understand that all images and materials from any photography are solely the property of SereneMax LLC and release all claims against SereneMax LLC with respect to copyright ownership and publication, including any claim for compensation related to the use of the materials.

Client/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LaserTechnicianSignature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Skin Type Worksheet**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **0** | **1** | **2** | **3** | **4** |
| **What is your eye color?** | Light blue or gray | Blue or green | Hazel, light brown | Dark brown | Brownish black |
| **What is the natural color of your hair?** | Red , Sandy red | Blond | Dark blonde, Chestnut, Brown | Dark brown | Black |
| **What is the color of your skin (unexposed areas)?** | Reddish | Very pale | Pale with beige tint | Light brown | Dark brown |
| **What happens when u stay in the sun too long?** | Painful redness,Blistering,Peeling | Blisteringfollowed bypeeling | BumsSometimes followed by peeling | Rarely bums | Never had a burn |
| **To what degree do you Turn brown?** | Hardly anyor not at all | Light tan | Reasonable tan | Tan very easily | Turn dark brown quickly |
| **Do you turn brown several hours after sun Exposure?** | Never | Seldom | Sometimes | Often | Always |
| **How does your face respond to the sun?** | Very sensitive | Sensitive | Normal | Very resistant | Never had a problem |
| **When did you last expose yourself to the sun, tanning beds or self tanning lotions?** | More than 3 months ago | 2-3 months ago | 1-2 months ago | Less than 1 month ago | Less than 2 weeks ago |
| **How often is the area you want to have treated exposed to the sun?** | Never | Hardly ever | Sometimes | Often | Always |

* Serene Max Laser Spa has 24 hour cancellation policy. This policy is in place out of respect for our staff and clients. Cancellations with less than 24 hours notice are difficult to fill. Also by giving last minute notice or no notice at all, you prevent someone else from taking your appointment. $50 fee will be charged to you for missed reservations that are rescheduled or canceled less then 24 hours in advance. Please fill Your Credit/Debit card \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Expiration Date \_\_\_\_\_\_, 3 digits CVV code on the back of the card (4 for American express) \_\_\_\_\_\_\_\_\_\_.
* All payments are non-refundable. Store credit only.
* Sales tax will be collected on behalf of city on all purchases. 0.5% account origination fee may be charged.

By signing below, you acknowledge that you have read and understand the above described policy. Thank you for your understanding and cooperation.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name Signature