GLO SKIN CARE & ANTI AGING BOUTIQUE'

CLIENT INTAKE & CONSENT FORM

Date: _____ Date of Birth: _____

Gender: ( ) Male ( ) Female

Name: _____

EMail address:_____

Address: _____

City: _____

State: _____ Zip Code: _____ Home Phone: _____

Work/Daytime Phone: _____ Cell: _____

Referred By: _____ Emergency Contact: _____

Emergency Contact Phone: _____ Contact Information

Ethnic Skin Type: ( ) Caucasian ( ) African-American ( ) Hispanic ( ) Asian ( ) Eastern Indian ( ) American Indian

Please list any health conditions you are experiencing:

_____

_____

_____

Have you ever taken or currently taking ( ) Retin A ( ) Accutane Topical or Oral Antibiotics: ( ) Oral ( ) Topical

What is the name of the antibiotic? _____ How often do you exercise? _____

What is your level of stress? Low 1 2 3 4 5 6 7 8 9 10 High How many hours of sleep to you get per night? _____

How many 8 oz. glasses of water do your drink each day? ___ How much caffeine and/or alcohol do you consume each day? __ Caffeine __ Alcohol

Do you smoke? Yes No Please list all supplements, medications, allergies or recent surgeries:_____

_____

_____

How much UV exposure do you get (sun, tanning beds, commuting in car:

_____

Medical Background Do you have any of the following: ( ) Scars ( ) Stretch Marks

( ) Hyper Pigmentation( )

Do you suffer from: ( ) Acne ( ) Blackheads ( ) Whiteheads ( ) Milia ( ) Oiliness ( ) Rosacea ( ) Dehydration ( ) Eczema ( ) Cellulite ( ) Vein/Circulation Problems ( ) Psoriasis Where: _____( ) Other: _____

Have you ever received any of the following treatments? ( ) Facial ( ) Microdermabrasion ( ) Laser Surgery ( ) Chemical Peels ( ) Waxing ( ) Lash/Brow Tint ( ) Laser Hair Removal ( ) Vein Treatments

Please select the box that applies to you: ( ) I never tan, always burn ( ) I tan with difficulty, usually burn ( ) Average Tanning, sometimes burn ( ) Easily tan, rarely burn ( ) I never burn

Client Self Assessment CLIENT INFORMED CONSENT TO TREATMENT

I, _____

consent to and authorize **Glo Skin Care & Anti Aging Boutique'** to perform skin exfoliation, skin waxing, facials, micro-dermabrasion, Chemical Peels, body treatments and other related skin care services and eyelash extentions.

Services:

_____

_____

•I have not used a scrub, Retin-A, Retinol A, take home micro-dermabrasion or glycolic peels in the last 72 hours. _____ (**Initial**)

•The nature and purpose of the treatment has been explained to me, and any questions I may have regarding this procedure has 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 unknown causes could occur. I freely assume these risks. . _____ (**Initial**)

•I have no allergies to Iodine. (Seaweed) . _____ (**Initia**l)

•I am not Epileptic and do not have heart or circulation problems. . _____ (**Initial**)

•Possible side effects include, 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 sore. Most side effects are temporary and generally fade within 72 hours. (Chemical Peels) . _____ (**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**)

•**It is recommended to discontinue use of all AHA's, Glycolics, Retin-A, Renova, or any exfoliating products for up to 72 hours post procedure.** Using hydrating, soothing, antioxidants for healing and ice for swelling and inflammation reduction. No sun exposure or tanning beds for 72 hours and use at least a SPF 15 sunscreen daily when receiving treatments is recommended. _____ (**Initial**)

•I agree to adhere to all safety precautions and home skin care program as recommended by **Glo Skin Care & Anti Aging Boutique'** . _____ (**Initial**)

•I am over 18 years of age, or I have a parental consent co-signed below. . _____ (**Initial**)

•I will call to inform **Glo Skin Care & Anti Aging Boutique'** of any complications or concerns I may have as soon as they occur. _____ (**Initial**)

•I have been off of Accutane for at least 12 months. . _____ (**Initial**)

I have voluntarily elected to undergo this treatment/procedure after the nature and purpose of this treatment has been explained to me, along with the risks and hazards involved.

Although it is impossible to list every potential risk and complication, I have been informed of possible benefits, risks, and complications.

I also recognize there are **no guaranteed results** and that independent results are dependent upon age, skin condition, and lifestyle and that there is the possibility

I may require further treatments of the treated areas to obtain the expected results at an additional cost. I have read and understand the post-treatment home care instructions.

I understand how important it is to follow all instructions given to me for post-treatment care. In the event that I may have additional questions or

concerns regarding my treatment or suggested home product/post-treatment care, **I will consult Glo Skin Care Anti Aging Boutique' immediately.**

I have also, to the best of my knowledge, given an accurate account of my medical history, including all known allergies or prescription drugs or products

I am currently ingesting or using topically. I have read and fully understand this agreement and all information detailed above. I understand the procedure and accept the risks.

All of my questions have been answered to my satisfaction and I consent to the terms of this agreement.

I do not hold **Glo Skin Care & Anti Aging Boutique'**, responsible for any of my conditions that were present, but not disclosed at the time of this skin care procedure,

which may be affected by the treatment performed today.

Client Name (Signature):

_____

Date: _____

Consent to Treatment of Minor: By my signature below, I hereby authorize **Glo Skin Care & Anti Aging Boutique'** to administer Aesthetic services, to my child or dependent, as she deems necessary.

Signature of Parent or Guardian:

_____

Date:_____