Bloom Skin Spa inc.

CLIENT PROFILE

(PLEASE PRINT)

DATE: _____ / _____ / _____ NAME: _____

SALUTATION: (Mr. / Mrs. / Ms. / Miss / Dr.) GENDER: M / F MINOR: Y / N

BIRTHDAY: _____ /_____ /_____ (the year is optional)

ADDRESS: _____APT/CONDO # _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: cell: (_____) _____ - _____ home: (_____) _____ - _____

work: (_____) _____ - _____ email: _____@_____

OCCUPATION: _____

EMERGENCY CONTACT

NAME: _____ RELATION: _____

PHONE: (_____) _____ - _____ OR (_____) _____ - _____

DERMATOLOGIST/PHYSICIAN

NAME: DR. _____ PRACTICE: _____

PHONE: (_____) _____ - _____ circle one: FAMILY / DERM / OTHER

HOW DID YOU HEAR ABOUT *Bloom Skin Spa*

NEWSPAPER	YELLOW PAGES	MAILER	FLYER
COUPON	MENU	BUSINESS CARD	REFERRAL
WEB LINK	SEARCH ENGINE	INTERNET ADVETISMENT	
WORK NEARBY	GIFT CERTIFICATE	OTHER _____	

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HAIR REMOVAL CONSENT FORM

(FIRST TIME CLIENT)

NAME: _____

Have you used any Alpha Hydroxy Acid (AHA) or glycolic products in the past 48-72 hours? YES / NO

Are you using Retin-a, Renova or Accutane (an oral form of Retin-a)? YES / NO

Are you using any other skin thinning products and/or drugs? YES / NO

Are you exposed to the sun on a daily basis or are you considering spending more time in the sun soon? YES / NO

Do you use a tanning bed? YES / NO

Are you diabetic? YES / NO

Are you currently taking medications? If so, please list all (including over the counter drugs/herbal supplements):

_____

_____

What skin products do you regularly use on your skin?

_____

Have you ever been treated for cancer? If yes, when and what types of therapies were used?

_____

_____

Please list any other illness/condition you are currently being treated for by a medical professional

_____

_____

What is your menstrual cycle due date? _____
(for bikini waxing only)

(Always allow five days for menstrual cycle. Because of water retention and for your own personal comfort, you should avoid hair removal two days before your cycle is due and two days after it is completed.)

Please note that waxing does have certain side effects such as skin removal, redness, swelling, tenderness, etc.

I have read the above information and if I have any concerns, I will address these with my skin therapist. I give permission to my therapist to perform the waxing procedure we have discussed and will hold her and her staff harmless from any liability that may result from this treatment.

I have given an accurate account of the questions asked above including all known allergies or prescription drugs or products I am currently ingesting or using topically. I understand my esthetician will take every precaution to minimize or eliminate negative reactions as much as possible.

I have read and understand the post-treatment home care instructions. I am willing to follow recommendations made by my esthetician for a home care regimen that can minimize or eliminate possible negative reactions. In the event that I may have additional questions or concerns regarding my treatment or suggested home product / post-treatment care, I will consult the esthetician immediately.

I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read, and fully understand the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered. I understand the procedure and accept the risks. I do not hold the esthetician, whose signature appears below, 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.

Patient Signature_____

Please print Name_____

Date_____/_____/_____

Esthetician _____

Date_____/_____/_____