

Natural Health and Healing Center Client Intake form – Laser Treatment

Name: _____ Date of Birth: _____

Date: _____ Address: _____ City: _____ State: _____

Email: _____ Please email me on Special Offers and Events: Yes or No

Phone (cell): _____ (home): _____

To better evaluate your needs, please answer the following questions:

How did you hear about us?

Magazine	Newspaper	Billboard	Radio	Phonebook	Sign out front	Friend	Family	Employee
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Physician Referral? (Who): _____

Other? _____

Are you using any of the following products?

Retin-A	Yes	No
Benzoyl Peroxide	Yes	No
Renova	Yes	No
Accutane	Yes	No
Birth Control Pills	Yes	No

	Circle	Other Comments
Are you currently pregnant or breast feeding?	Yes No	
Do you get cold sores (herpes)?	Yes No	
Do you have a latex allergy?	Yes No	
Do you get keloid scars?	Yes No	
Do you take Aspirin or Aspirin products daily?	Yes No	
Do you have immune deficiency disorder (HIV)?	Yes No	
Are you receiving Chemotherapy?	Yes No	
Do you have any known food or drug allergies?	Yes No	
Any recent surgery?	Yes No	
Do you have rosacea?	Yes No	
Are you using any topical medications?	Yes No	
Are you using a retinoid?	Yes No	
Are you using exfoliating acids?	Yes No	
Do you have any implants?	Yes No	
Do you wear contact lenses?	Yes No	
Have you undergone treatment from a dermatologist?	Yes No	
Have you ever had an adverse reaction to a product?	Yes No	

List vitamins and medications you currently take _____

What are you currently using to cleanse your face? _____

What are you currently using to moisturize? _____

Special Treatments (Eye Cream, Night Cream, Masks)? _____

What improvements would you like to see on your skin? _____

These are the areas of concern for me:	Check
Fine Lines and Wrinkles	
Frown Lines between the brows	
Wrinkles/Lines around the nose and mouth	
Length/Thickness of eyelashes	
Facials and eye treatment	
Facial Veins	
Spider Vein Treatment	
Hair Removal	
Removing Leg Veins	
Age spots/Liver Spots	
Birthmarks	
Skin Care Products	
Skin Care Advice	
Sagging/Loose Skin	
Uneven Skin Tone	
Acne	
Unwanted Hair	
Dark Circles Under Eyes	
Freckles/Sun Damage	
Dryness	
Cellulite	
Other:	

Please check only ONE of the following:

My skin is somewhat oily in the T-Zone, but not oily all over	
Undeniably oily all over, even in the cheek area	
Noticeably dry all over	
Oily or normal with patches of dry areas	

Fitzpatrick Classification Questionnaire

	0	1	2	3	4	Score
What is the natural color of your hair?	Sandy/Red	Blonde	Chestnut, Dark Blonde	Dark Brown	Black	
What is the color of the sun exposed skin areas?	Reddish	Very Pale	Pale with beige tint	Light brown	Dark brown	
Do you have freckles on sun exposed areas?	Many	Several	Few	Incidental	None	
What happens when you are in the sun too long without sun block?	Painful redness, blistering, peeling	Blistering followed by peeling	Burns, sometimes followed by peeling	Rarely burns	Never had a problem	
How well do you tan?	Hardly or not at all	Light color tan	Reasonable tan	Tan very easily	Turn dark very quickly	
Do you tan within one day of 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 or artificial sun treatments?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than 1 month ago	Less than 2 weeks ago	
Do you expose the area to be treated, to the sun?	Never	Hardly ever	Sometimes	Often	Always	

- 00-07 points = Skin type I
- 08-16 points = Skin type II
- 17-25 points = Skin type III
- 25-30 points = Skin type IV
- 30-40 points = Skin type V & VI

Natural Health and Healing
Informed Consent form for Laser Treatment

New to the procedure? Every office or every laser may be different and can result in different side effects.

Whether you have gotten laser treatments before from another office and have had no issues, that may not be the case at a different office because every technology and laser is different. In correspondence with, every skin type and individual may react to each technology differently.

At our office we use a diode laser;

Which skin type is the diode laser suitable for?

A diode laser is suitable for skin types 1-4 and can cautiously be used on skin type 5 and 6.

What are the advantages of a diode laser vs. other hair removal machines?

The diode laser features a longer wavelength and provides deeper penetration into the skin resulting in better hair removal.

What are the side effects of using a diode laser vs. other hair removal machines?

Side effects may entitle;

Burning
Blistering
Scab formation
Pain
Redness
Skin discoloration (hypo and hyper pigmentation)
Swelling
Fragile skin
Bruising
Scarring

I have read the above statements and understand that the use of different lasers in various locations may result in different side effects depending on each location. I am aware of the potential side effects and the risks of using the laser at the Natural Health and Healing Center location and give consent to continue with the procedure.

Signature: _____ Date: _____

Natural Health and Healing Center
Laser Treatment Informed Consent

I authorize Natural Health and Healing Center's licensed esthetician/skin care specialist to perform E-Max Laser Hair Removal or Intense Pulsed Light laser treatments on me.

I understand that the following procedure may cause short term side effects such as; burns, blistering, scabbing, flaking of the skin, pain, temporary bruising and discoloration of the skin (hypo/hyperpigmentation) as well as other possible side effects. The possibility of long term side effects such as burns, pain, permanent scarring and permanent discoloration of the skin. I understand that anytime the skin barrier is compromised an infection may occur. These effects have been explained to me.

Clinical results may vary depending on individual factors such as; medical history, skin type, patient compliance with pre/post treatment instructions and individual response may vary. Unprotected sun exposure in the weeks before and after treatment is contraindicated and may cause or worsen side effects.

I certify that I have been informed of the nature and purpose of the treatment that I am receiving and the possible complications that can occur. I UNDERSTAND THAT NO GUARANTEE CAN BE GIVEN AS THE FINAL RESULT OBTAINED. I AM FULLY AWARE THAT MY CONDITION IS OF COSMETIC CONCERN; I UNDERSTAND I AM TAKING THE CHANCE OF DEVELOPING SIDE EFFECTS, SHORT TERM OR LONG TERM. THE DECISION IS BASED SOLELY ON MY EXPRESSED DESIRE TO HAVE THE TREATMENT PERFORMED.

I confirm that I am not pregnant at this time, have not taken Accutane within the last 6 months. I do not have a pacemaker or internal defibrillator. I do not have a history of keloid scars and do not have poorly controlled diabetes.

I certify that I have been given the opportunity to ask questions and that I have fully read and understand the contents of this consent form.

Patient Name: _____ Date: _____

Patient Signature: _____

Patient Signature if under the age of 18: _____