

SKINCITY

LASER HAIR REMOVAL CONSULTATION FORM

CLIENT INFORMATION

Name: _____ Gender: _____

Date of Birth (D.O.B): _____ Phone #: _____

Address: _____

City: _____ Zip: _____

Email _____ Ethnic Ancestry: _____

Emergency Contact Name: _____ Relationship: _____

Phone: _____

WHAT AREA/AREAS WOULD YOU LIKE TO BE TREATED:

Face:

- Upper Lip
- Chin
- Side Burns
- Full face

Upper body:

- Full arms
- Half arms
- Under arms
- Back/shoulder
- Abdomen
- Stomach Line
- Chest

Lower body:

- Full legs
- Half legs
- Brazilian
- Bikini
- Between the cheeks

Other:

- Areola
- Neck
- Full body
- Other: _____

MEDICAL HISTORY

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

If yes, please explain: _____

Do you have history of skin cancer or atypical moles? No Yes

If yes, please explain: _____

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

If yes, please explain: _____

Are you taking or have you been treated with hormone medication? No Yes

If yes, please explain: _____

Have you had or have herpes or cold sores in the treatment area? No Yes

If yes, please explain: _____

Do you have any unusual scars? if so, Where? No Yes

If yes, please explain: _____

Do you have any allergies? (e.g., topical anesthetics, latex, etc.) No Yes

If yes, please list all: _____

Do you have any skin conditions in the treatment area? (e.g., eczema, psoriasis, etc.) No Yes

If yes, please explain: _____

Do you have an Autoimmune Disorder? (e.g., lupus, vitiligo, scleroderma, etc?) No Yes

If yes, please explain: _____

Do you have a history of keloid scarring? No Yes

If yes, please explain: _____

List all medications you take and when you last took them specially the following: Accutane (isotretinoin), photosensitizing drugs, St. John's Wort, and gold salt injections.

MEDICAL HISTORY

Do you currently have or have you had any of the following conditions? If yes, please select them:

- | | | |
|---|--|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Hirsutism | <input type="checkbox"/> Multiple Sclerosis/ALS |
| <input type="checkbox"/> Active Infection | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Hypo/Hyper Pigmentation | <input type="checkbox"/> Photosensitivity |
| <input type="checkbox"/> Bell's Palsy | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Polycystic Ovaries |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Irregular Periods | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Keloid Scarring | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Eczema/Rashes | <input type="checkbox"/> Lesions, Open wounds | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Low/High Blood Pressure | <input type="checkbox"/> Skin Cancer |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Lupus | <input type="checkbox"/> Thyroid Imbalance |
| <input type="checkbox"/> Herpes | <input type="checkbox"/> Menopause | <input type="checkbox"/> Vitiligo |
| | | <input type="checkbox"/> Warts |

Any other conditions? _____

SKIN HISTORY

For Face Treatments only List any skin care products you currently used: No Yes

Do you have any abrasions, moles or skin irritations in the area(s) to be treated? No Yes

If yes, please explain: _____

Do you have a history of excessive scarring or pigmentation changes after previous skin treatments or injuries? No Yes

If yes, please explain: _____

SKIN HISTORY

Have you used Accutane or Immunosuppressants in the last 6 months? No Yes

Any Retin-A, Retinol, AHA or acid-containing products in the last 7 days? No Yes

Do you have any tattoos or permanent makeup in the area(s) to be treated? No Yes

Are you exposed to the sun on a daily basis? No Yes

Do you currently have a sunburn or a tan? No Yes

Does your skin get blotchy, red, or irritated easily? No Yes

Do you plan on spending time in the sun soon? No Yes

Have you recently used a tanning bed/tanning lotions/spray tan? No Yes

Have you recently had a chemical, glycolic peel or laser resurfacing? No Yes

Have you had botox or dema fillers recently? No Yes

Is your skin sensitive to soaps/lotions/hydroquinone/skin bleaching agents? No Yes

Have you had your hair professionally removed before? No Yes

If yes, please list areas, methods used (Laser, plucking, waxing, electrolysis) and date last removed:

Please consult with a healthcare professional if you have any concerns about the information provided in this form.

By signing below, you agree to the following:

I attest the above information to be true, knowing the technician relies on this for a safe and effective treatment. I agree to inform the technician of any changes in the above information. I agree to waive all liabilities toward SKINCITY - LASER STUDIO, and any of their associates for any injury or damages incurred due to any misrepresentation of my health history.

Client Name (printed)

Client Name (signature)

Date

Technician (signature)

Date

The below signed parent or legal guardian of the above-named minor child hereby consents to and gives permission to the above on behalf of such minor child.

Signature of Parent or Legal Guardian: _____ Print Name: _____ Date: _____

SKINCITY

LASER HAIR REMOVAL

CLIENT CONSENT

POSSIBLE TREATMENT METHODS:

Included but not limited to laser hair removal or benign pigmented lesions.

POSSIBLE TREATMENT AREAS:

included but not limited to eyebrow, lip, chin, neck, sideburns, face, arms, fingers, chest, areola, stomach, underarms, back, buttocks, bikini, labia, scrotum, thighs, legs, feet or toes.

RISKS

Every procedure involves certain amount of risk as it is important that you understand these risks and the possible complications associated with them.

Please initial to acknowledge that you are aware of the following possible experiences/complications/risks with the Laser Treatment:

_____ DISCOMFORT – Some discomfort may be experienced during laser treatment.

_____ WOUND HEALING – Laser can result in swelling, redness, blistering, crusting, scabs, or flaking of the treated areas, which may require time to heal. This can take days or weeks, depending on the patient. Once the surface has healed, it may be pink or sensitive to the sun. It's crucial to protect healed area from sun exposure.

_____ BRUISING/SWELLING/INFECTION – With some lasers, bruising of the treated area may occur. Additionally, there may be some swelling noted. Finally, skin infection can occur although rare if the treated area becomes contaminated or if the skin is not properly cared for after the procedure.

_____ PIGMENT CHANGES (Skin Color) – During the healing process there is a slight possibility that the treated area can become either hypo-pigmented (lighter) or hyper-pigmented (darker) compared to the surrounding skin. This is usually temporary, but in some cases, it can become permanent.

_____ SCARRING – Scarring is a rare occurrence, but it is a possibility when the skin's surface is disrupted. To minimize the chances of scarring, it is IMPORTANT that you follow all post-treatment instructions carefully.

_____ EYE EXPOSURE – While protective eyewear (shields) will be provided, it is important to keep these shields on at all times during the treatment in order to protect your eyes from accidental laser exposure.

Client Initials: _____

_____ There is also the possibility that other side effects or complications, not presently known or recognized, may develop now, or in the future.

****Compliance with the aftercare guidelines is essential for optimizing the results and ensuring a smooth recovery following a laser hair removal treatment****

ACKNOWLEDGMENT:

_____ I am aware that treatments may not meet my expectations

_____ I am aware there is a possibility that an imperfection might ensue.

_____ I am aware of possible risks and complications involved with the proposed procedure and subsequent healing period, including, but not limited to infection, scarring, crusting, regrowth of hair, and/or blistering.

_____ I understand that exposure to laser light could harm my vision and must keep eye protection goggle on at all times.

_____ I have read and understood post treatment instructions.

By signing below, I hereby acknowledge that I have read and fully understand all the information in this consent agreement. I agree to receive the laser treatment or series of laser treatments while fully understanding the risks and side effects associated with the treatment. I freely assume these risks and release SKINCITY LASER STUDIO, of all liability.

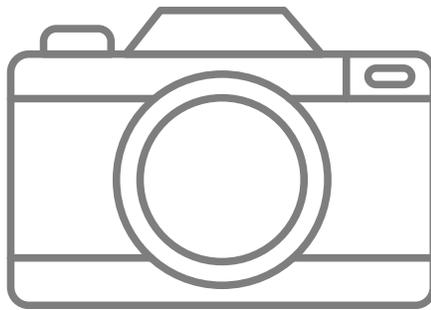
Client Name (printed)

Client Name (signature)

Date

The below signed parent or legal guardian of the above-named minor child hereby consents to and gives permission to the above on behalf of such minor child.

Signature of Parent or Legal Guardian: _____ Print Name: _____ Date: _____



LASER HAIR REMOVAL PHOTO & VIDEO RELEASE FORM

I, _____ hereby do do not grant and authorize SKINCITY LASER STUDIO the right to take, edit, alter, copy, exhibit, publish, distribute and make use of any pictures, videos and /or audio recordings of me to be used for any lawful promotional materials including, but not limited to, newsletters, flyers, posters, brochures, advertisements, press kits, websites, social media, and other print and digital communications, without payment or any other consideration.

This authorization shall continue indefinitely and extends to all languages, media, formats, and makets now known or later discovered.

I waive any rights to royalties or other compensation for the use of these materials.

I understand and agree that these materials will become the property of SKINCITY LASER STUDIO and will not be returned to me.

I hereby release SKINCITY LASER STUDIO from any liability, petitions, or legal claims that may arise from the use of these materials, both on my behalf and on behalf of my estate, and hold them harmless.

By signing below, I hereby acknowledge that I have completely read and fully understand the above release agreement.

Client Name (printed)

Client Name (signature)

Date

The below signed parent or legal guardian of the above-named minor child hereby consents to and gives permission to the above on behalf of such minor child.

Signature of Parent _____ Print Name: _____ Date: _____
or Legal Guardian:

FITZPATRICK SKIN TYPE EVALUATOR



Client Name: _____ Date: _____

| GENETIC DISPOSITION | 0 | 1 | 2 | 3 | 4 | SCORE |
|---|---------------------------|-----------------------|----------------------|-------------|----------------|-------|
| What is your natural eye colour? | Light blue or light green | Blue, green, or hazel | Light Brown | Dark brown | Brownish black | |
| What is your natural hair colour? | Sandy red | Blonde | Chestnut, dark blond | Dark brown | Black | |
| What is the colour of your (non exposed) skin? | Reddish | Very pale | Pale with beige tint | Light brown | Dark brown | |
| Do you have freckles on areas not exposed to sun? | Many | Several | Few | Incidental | None | |

GENETIC DISPOSITION TOTAL: _____

| REACTION TO SUN EXPOSURE | 0 | 1 | 2 | 3 | 4 | SCORE |
|--|---------------------------------------|--------------------------------|-------------------------------------|-----------------|--------------------------|-------|
| What happens when you stay in the sun too long? | Painful, redness, blistering, peeling | Blistering followed by peeling | Burns sometimes followed by peeling | Rarely burns | Never burns | |
| To what degree do you turn brown? | Hardly or not at all | Light color tan | Reasonable tan | Tan very easily | Turn dark, brown quickly | |
| Do you turn brown within several hours after sun exposure? | Never | Seldom | Sometimes | Often | Always | |
| How does your face react to the sun? | Very sensitive | Sensitive | Normal | Very resistant | Never had a problem | |

REACTION TO SUN EXPOSURE TOTAL: _____

| TANNIN HABITS | 0 | 1 | 2 | 3 | 4 | SCORE |
|--|------------------------|----------------|----------------|-----------------------|-----------------------|-------|
| When did you last expose your body to sun, a tanning bed or tanning cream? | 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 wear sunscreen or protect your face every time you are outside? | Always | Often | Sometimes | Hardly ever | Never | |

TANNING HABITS TOTAL: _____

| SKIN TYPE SCORE | FITZPATRICK SKIN TYPE |
|-----------------|-----------------------|
| 0-7 | I |
| 8-16 | II |
| 17-25 | III |
| 26-30 | IV |
| Over 30 | V - VI |

| | |
|------------------------|--|
| TOTAL SKIN TYPE SCORE: | |
|------------------------|--|

| | |
|-----------------------|--|
| FITZPATRICK SKIN TYPE | |
|-----------------------|--|