european
SKINCARE & MED SPA

## CLIENT INFORMATION & INFORMED CONSENT

Today's Date (MM/DD/YY)____/____/____ As of today's date, are you over the age of 18? Yes____ No____

First Name_____ Last Name_____

Emergency Contact: Name_____ Phone #_____ Relationship_____

Have you seen a health care provider in the last 2 years? If yes, what for?_____

Are you currently under his/her care? Yes____ No____ What for?_____

**Please indicate if you have/had the following:**

| | | | |
|---|---|---|---|
| □ Recent surgery or acute injury | □ Hepatitis | □ Herpes | □ Arthritis/Joint Disorder |
| □ Cardiac/Circulatory Problems | □ Breast Cancer/Radiation | □ Actinic keratosis | □ Numbness/Stabbing Pains |
| □ Skin Disease/Skin Lesions | □ Psoriasis | □ Frequent cold sores | □ Blood Clotting |
| □ Using Retin-A® or Accutane® | □ Skin Problems | □ History of Seizures | □ Allergic to Vegetable Dyes |
| □ Presence of raised moles/warts | □ Allergies | □ Pacemaker | □ Immuno-suppression |
| □ Hyper/Hypo-pigmentation | □ High Blood Pressure | □ Keloid Scars | □ Do you bruise easily? |
| □ Cancer/Malignant Tumors | □ Spinal Problems | □ Dermal Filler | □ Blood Thinning Medications (Aspirin) |
| □ Hormonal Imbalance | □ Claustrophobia | □ Epilepsy | □ Varicose/Spider Veins |
| □ Pregnant (or think you might be) or nursing | □ Active infection | □ HIV or AIDS | □ Thyroid Imbalance |
| □ Taking Birth control | □ Eczema | □ Hemophilia | □ Diabetes |
| □ Topical medications or creams | □ Oral Topical Antibiotics | □ Eye Problems | □ Do you wear contact lenses? |

□ Skin Peels or Laser Treatments/Surgery in the last six weeks

□ Recent sun exposure, tanning bed exposure, or self tanner. If so, How often?____ When tanning, do you burn easily?____

□ Allergic reaction to: □ *Food* □ *Latex* □ *Aspirin* □*Lidocaine* □ *Hydrocortisone* □ *Hydroquinone* or skin bleaching agents □ *Other*_____

Please list current medications, supplements & cosmetics_____

Which, if any, cosmetics/skin care products are you allergic to?_____

Do you have any medical condition that we should be aware of?_____

What do you expect from this visit? (Example: scar reduction, improve acne, relaxation, etc)_____

**Photography**

I do ____ or do not _____ consent to photographs and other audio-visual and graphic materials before, during, and after the course of my therapy to be used for medical, marketing, and education purposes. Although the photographs or accompanying material will not contain my name or any other identifying information, I am aware that I may or may not be identified by the photos.

**PLEASE READ CAREFULLY:** With my signature below, I certify that I'm at least 18 years old and that I have fully disclosed my medical history and have answered all the specific health questions. I have had the opportunity to ask questions regarding the treatment/procedure and my questions have been answered to my satisfaction. I have been satisfactorily informed of possible risks (if any) and benefits (if any) of the proposed treatment(s), authorize and direct ESI to perform the procedure and understand that results cannot be guaranteed. When applicable, aftercare guidelines are crucial for healing and prevention of scarring, hypo- and hyper-pigmentation and other conditions, and I understand that copies of "Post Treatment Suggestion" forms are available to me at no charge. I will also notify European Skincare & Med Spa of any changes in my health as they occur during my treatment program, as well as the addition of new medication, birth control pills, herbs, supplements, vitamins not listed above. As a client/patient of European Skincare & Med Spa, I understand and agree to abide by the spa's no-show cancellation policy.

_____ _____

Client/Patient Signature Parent/Guardian Signature (if under 18 years)