LASER HAIR REMOVAL

DIGITAL FORMS

CLIENT NAME:

LASER HAIR REMOVAL

CLIENT INTAKE FORM

CLIENT INFORMATION

Name: ______________________________ D.O.B: ____________

Occupation: ______________ Age: ________ ☐ Female ☐ Male ☐ NB

Address: ______________________________

City: ______________ State: ________ Zip: ____________

Phone: ______________ Email: ______________________

Emergency contact: ______________________ Phone #: ____________

Would you like to be added to our email list for news and exclusive offers? *Yes* ☐ *No* ☐

MEDICAL HISTORY

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

- ☐ Acne
- ☐ Active Infection
- ☐ Anaphylaxis
- ☐ Arthritis
- ☐ Autoimmune Disease
- ☐ Bell's Palsy
- ☐ Bleeding Disorders
- ☐ Breathing Problems/Disease
- ☐ Cold Sores (HSV1)
- ☐ Liver/Kidney Dysfunction
- ☐ Diabetes
- ☐ Eczema/Rashes
- ☐ Epilepsy/Seizures
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes (HSV2)
- ☐ Hirsutism
- ☐ HIV/AIDS
- ☐ Hypo/Hyper Pigmentation
- ☐ Hysterectomy
- ☐ Implantable Defibrillator
- ☐ Irregular Periods
- ☐ Keloid Scarring
- ☐ Low/High Blood Pressure
- ☐ Menopause
- ☐ Multiple Sclerosis/ALS
- ☐ Lesions, Open wounds
- ☐ Lupus
- ☐ Pacemaker
- ☐ Photosensitivity
- ☐ Polycystic Ovaries
- ☐ Poor Blood Circulations
- ☐ Pregnant
- ☐ Psoriasis
- ☐ Shingles
- ☐ Skin Cancer
- ☐ Thyroid Imbalance
- ☐ Vitiligo
- ☐ Warts

Do you have any allergies: ☐ No ☐ Yes ______________________

List any medications/supplements you are currently taking: ______________________

____

LASER HAIR REMOVAL

CLIENT INTAKE FORM

Are you currently under a doctor's care? ☐ No ☐ Yes
If yes, please explain: ________________

Have you ever been treated for cancer? ☐ No ☐ Yes
If yes, please explain: ________________

Do you have any implants? ☐ No ☐ Yes
If yes, please explain: ________________

Have you ever been treated with hormone medication? ☐ No ☐ Yes
If yes, please explain: ________________

Have you had any severe reactions to histamines? ☐ No ☐ Yes
If yes, please explain: ________________

Any previous surgeries? ☐ No ☐ Yes
If yes, please explain: ________________

Do you have any allergies? ☐ No ☐ Yes
If yes, please list all: ________________

List all medications you take, including vitamins, herbal supplements, aspirin, hormones and topical:
____

♀ When is your next menstrual cycle due to begin? ________________
(For your comfort, allow five days for your menstrual cycle. Avoid hair removal two days before your cycle is due and two days after it is completed.)

Are you pregnant, trying to become pregnant or nursing? ☐ No ☐ Yes

LASER HAIR REMOVAL

CLIENT INTAKE FORM

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 use any other products / drugs that cause photosensitivity?	☐ No	☐ Yes
Are you exposed to the sun on a daily basis?	☐ No	☐ Yes
Do you currently have a sunburn?	☐ No	☐ Yes
Does your skin get blotchy, red, or irritated easily?	☐ No	☐ Yes
Do you plan on spending more 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
Is your skin sensitive to soaps/lotions/hydroquinone/skin bleaching agents?	☐ No	☐ Yes
Have you had a tattoo or permanent makeup in the area(s) to be treated?	☐ No	☐ Yes
In the last 6 months, have you had Botox/Fillers in the area(s) to be treated?	☐ No	☐ Yes

Do you have any abrasions, moles or skin irritations in the area(s) to be treated?

____

Please list any skin care products you currently use:

____

Have you had your hair professionally removed before? ☐ No ☐ Yes

If yes, please list areas, methods used and date last removed:

____

____

LASER HAIR REMOVAL

CLIENT INTAKE FORM

WHAT SERVICE WOULD YOU LIKE:

Face & Brows:

- ☐ Brow
- ☐ Lip
- ☐ Chin
- ☐ Full face
- ☐ Side bums

Upper body:

- ☐ Full arms
- ☐ Half arms
- ☐ Under arms
- ☐ Back/shoulder
- ☐ Abdomen
- ☐ Chest

Lower body:

- ☐ Full legs
- ☐ Half legs

Other:

- ☐ Brazilian
- ☐ Bikini
- ☐ Full body
- ☐ Other: ________

By signing below, you agree to the following:

I have completed this form truthfully and to the best of my knowledge. I agree to inform the technician of any changes in the above information. I agree to waive all liabilities 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*

L A S E R   H A I R   R E M O V A L

CONSENT FORMS

Client legal name: ____

I hereby consent to and authorize ______________________________ to perform laser hair removal on me. I understand that this procedure works on the growing hairs and not on dormant hairs. For this reason, complete destruction of all hair follicles from any one treatment is unlikely, and I understand that I will require several treatments to obtain a significant, long-term reduction of hair growth. I also understand that maintenance treatments are needed to keep the growth away and that some people may not experience complete hair loss even with multiple laser procedures.

Please initial to acknowledge that you have been informed of the following:

______ The potential benefits of the proposed procedure.

______ Possible alternative procedures.

______ The probability of success.

______ 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.

______ Pre and Post treatment instructions.

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 Surgery can result in swelling, blistering, crusting, or flaking of the treated areas, which may require one to three weeks to heal. Once the surface has healed, it may be pink or sensitive to the sun for an additional two to four weeks, or longer in some patients.

______ Bruising/Swelling/Infection – With some lasers, bruising of the treated area may occur. Additionally, there may be some swelling noted. Finally, skin infection is a possibility, although rare, whenever a skin procedure is performed.

Client Initials: ________

LASER HAIR REMOVAL

CONSENT FORMS

_______ Pigment changes (Skin Color) – During the healing process there is a slight possibility that the treated area can become either lighter or darker in color compared to the surrounding skin. This is usually temporary, but on rare occasion, 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 – 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.

_______ I understand that the laser treatment is not appropriate for individuals who:

- Are pregnant or nursing.
- Are prone to keloid formation.
- Have a history of poor wound healing.
- Are taking medication which creates light sensitivity.
- Are taking anti-seizure medication.
- Are hypersensitive to light.
- Have a personal or family history of skin cancer.
- Have undiagnosed lesions.
- Had a recent herpetic outbreak.
- Have unstable diabetes or an autoimmune disorder.
- Have a photosensitive skin disorder.

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 and I will adhere to all of the aforementioned statements that I have initialed. I understand that this consent agreement is legal and binding and will remain in effect for this procedure and all future follow-ups conducted by my technician, and any of their associates. I fully understand the risks and side effects associated with the treatment. I freely assume these risks and release the technician, and any of their associates of all liability.

____

Technician (signature)

____

Client Name (signature)

____

Date

LASER HAIR REMOVAL
INFORMED CONSENT

GENERAL INFORMATION

Laser hair reduction offers results that cannot be achieved with conventional shaving or waxing. The laser works by targeting the hair in the follicle, below the skin's surface. The laser energy is transformed into heat which destroys the hair follicle leaving the surrounding skin unaffected. Facial areas, bikini area, upper and lower legs, arms, chest, and back may be treated leaving the skin smooth, stubble free, and without the irritation of ingrown hairs. In an hour or less, most body areas can be hair free. While some areas of the body are more sensitive than others, most patients report little or no discomfort. Again, this is a no down time procedure.

Hair grows in cycles. A minimum of four to six treatments will be necessary as the process is not effective on hair during the early growth cycle. After each session you will see substantial visible hair reduction. Each laser hair removal treatment will result in hair growth reduction. Additionally, hair will grow progressively slower, lighter, and finer with each treatment. It takes more than one treatment to affect all the follicles growing in an area.

The number of sessions will vary for each individual. During the initial visit the laser light disables those follicles in the "active" phase of the growth cycle. Follicles in the "dormant" phase will not be affected. Since follicles cycle through "active" and "dormant" phases, additional sessions may be desired once the "dormant" follicles become "active." Most people achieve satisfactory clearance after four to six treatments, but individual results may vary depending on medical and genetic factors. Lighter colored hair may require more treatments than darker colored hair.

Since no procedure can guarantee permanent hair removal, most patients can expect a 60% to 70% reduction in hair growth.

Client Initials: __________

L A S E R   H A I R   R E M O V A L

INFORMED CONSENT

PRE-TREATMENT

- Please make sure your skin is at its natural color. No sun exposure 2-4 weeks before and after treatment. Please make sure you have completely removed your spray tan using an alcohol wipe. No tanning lotions, tanning beds, tanning sprays and tanning solutions during treatment. You must cover all treated areas. Sunblock 30 SPF or higher is a must.
- You may not be taking or have taken antibiotics for a minimum of 14 days prior to receiving laser treatment. We will not laser if you have taken, or applied, antibiotics for a minimum of 14 days after your last dose.
- You may not be taking Aspirin or blood thinning medications for a minimum of 14 days prior to receiving laser treatment. Please avoid iron (in any form) 65mg, and above, for at least 3 days before and after your treatment. Please consult with your primary Physician prior to discontinuing the use of any of the medications listed above.
- You may not be taking Retin-A, Retinol, Benzoyl Peroxide, and/or Niacinimide, Salicyclic, Hyaluronic, and other acid-containing products for a minimum of 7 days prior to receiving laser treatment. Please consult with your primary Physician prior to discontinuing the use of any of the medications listed above.
- You may not have used Accutane or Immunosuppressants for a minimum of 6 months prior to receiving laser treatment.
- You may not receive facial treatments, microdermabrasion, or chemical peels for a minimum of 14 days prior to receiving laser treatment.
- Please remove all makeup, deodorant, lotion and ointments from the areas to be treated. Please arrive to your laser treatment clean and bare of all products. We recommend coming in loose and comfortable clothing to maximize your comfort and experience.
- Please shave 24-48 hours prior to your appointment. Do not wax, pluck, tweeze, thread, bleach, use Nair, etc.
- You may not have any type of laser treatment if you are (or think you may be) pregnant or nursing.

Client Initials: __________

LASER HAIR REMOVAL

INFORMED CONSENT

POST-TREATMENT

- Immediately after the treatments, there may be redness and bumps, which may last up to 2 hours or longer. It is normal for the treated area to feel like sunburn for a few hours.
- Allergic reactions such as swelling, itching and/or hives are common. Oral or topical antihistamine, Hydrocortisone or Benadryl can be used.
- Sunblock is imperative! It must be applied several times daily, especially if you are spending time outdoors. Sunblock 30 SPF or higher is preferred. BE ADVISED that not using sunblock properly may cause hyper-pigmentation, which can last several months to years.
- Avoid sun exposure, tanning lotions, tanning beds, tanning sprays, and tanning solutions 2-4 weeks after treatments.
- Avoid picking or scratching the treated skin.
- Anywhere from 5-30 days after the treatment, shedding of the hair may occur and this may appear as new hair growth. This is not new hair growth, but dead hair pushing its way out of the follicle.
- Do not use any other hair removal methods or products on the treated area during the course of your laser treatments, as it will prevent you from achieving your best results. Shaving is permitted if needed between sessions.
- Makeup may be used 24-hours after the treatment, unless there is epidermal blistering. It is recommended to use new makeup to reduce the possibility of infection.
- Do not exercise or use deodorant for 24 hours post treatment. No Jacuzzi, sauna, steam room, or hot showers 24-72 hours post treatment.
- You may not receive facial treatments, microdermabrasion, or chemical peels for a minimum of 14 days post laser treatment.
- Hair re-growth occurs at different rates on different areas of the body. You may not see the hair growing or pushing out evenly throughout treatments, but this does not mean the treatment is not working. Please remember laser hair removal is a treatment process and true results will be seen gradually.
- The recommended return time is between 4-6 weeks for laser hair removal.

Client Initials: __________

LASER HAIR REMOVAL

INFORMED CONSENT

I understand that the information on this Laser Hair Removal Informed Consent Form is essential to my medical and cosmetic condition and the success of my treatments. I have been informed and understand that the practice of medicine is not an exact science and that no guarantees can be or have been made concerning the expected results. I understand that whilst complications from this procedure are rare, they can and sometimes do occur. I understand clinical results may vary patient to patient. Multiple treatments or additional touch-ups may be necessary to achieve desired results.

I will not hold the technician, and their associates responsible for any risks associated with their provided treatments, as I am fully aware in my understanding, and I am still willing to be treated at my own free will. I understand that the technician, and any of their associates reserves the right to refuse service to anyone. I accept responsibility for any complications that may occur and thereby absolve the technician, and all of their associates of any blame resulting therefrom.

Informed consent documents are not intended to define or serve as the standard of medical care. Standards of medical care are determined on the basis of all the facts involved in an individual case, and are subject to change as scientific knowledge and technology advance and as practice of patterns evolve.

By signing below, I hereby acknowledge that I have read and understand all the information in this informed consent agreement. I understand that this agreement is legal and binding and will remain in effect for this procedure and all future follow-ups conducted by the technician, and any of their associates. I fully understand the risks and side effects associated with the treatment. I freely assume these risks and release the technician, and any of their associates of all liability.

____

Technician (signature)

____

Client Name (signature)

____

Date

LASER HAIR REMOVAL

AFTERCARE ADVICE

Avoid sun and tanning lotion for at least 2 weeks.

No spas, steam rooms or saunas for 72 hours.

Apply an ice-pack to reduce swelling and pain.

Use SPF 30+ for at least 2 weeks.

Avoid shaving the area for at least 72 hours.

Avoid makeup, lotion & deodorants for 24 hours.

No picking or scratching the treatment area.

Avoid exercising for at least 24 hours.

- Do not use any other hair removal methods other than shaving between treatments.
- Schedule your next appointment in 4-6 weeks for best results.

LASER HAIR REMOVAL

CLIENT RECORD

CLIENT INFORMATION

Name: ______________________________ Date: ____________

Phone: ______________ Mail: ______________

DATE	AREA TREATED	SETTINGS USED	NOTES	PRICE

LASER HAIR REMOVAL
FITZPATRICK ASSESSMENT

Client Name: ______________________________ Date: __________

ANALYSIS	0	1	2	3	4	SCORE
Natural eye color?	Light blue, gray or green	Blue, gray or green	Blue	Dark brown	Brownish black	
Natural hair color? (prior to grey)	Sandy red	Blond	Chestnut, dark blond	Dark brown	Black	
Skin color? (non-exposed)	Reddish	Very pale	Pale with beige tint	Light brown	Dark brown	
Freckles on unexposed areas?	Many	Several	Few	Incidental	None	

GENETIC DISPOSITION TOTAL: __________

ANALYSIS	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 had burns	
To what degree to 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: __________

ANALYSIS	0	1	2	3	4	SCORE
When did you last expose your body to sun, tanning bed or cream?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than 1 month ago	Less than 2 weeks ago	
Was the area to be treated exposed to the sun, tanning bed or cream?	Never	Hardly ever	Sometimes	Often	Always	

TANNING HABITS TOTAL: __________

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

TOTAL SKIN TYPE SCORE:	

FITZPATRICK SKIN TYPE	

L A S E R   H A I R   R E M O V A L

PHOTOGRAPH AND VIDEO RELEASE FORM

CLIENT INFORMATION

Name: ______________________________ Date: ______________

Phone: ______________ Mail: ______________

I would like your permission to use these photos for advertising. For example: Portfolios, online and print ads, etc. Your consent is necessary regarding this. Please circle and indicate with your signature if you would like your photos used or not used in advertising. We also like to tag our clients in photos used on our Instagram profile! Please indicate if you'd like to allow this or not below.

- ☐ Yes, feel free to use them
- ☐ Yes please tag me on Instagram
- ☐ No, please do not use them
- ☐ No, please do not tag me

______________________________ ______________________________

Client Name (printed signature) *Client Name (signature)*

____

Date