LUMIÉRE413
BY LINA

Confidential Client Health History Form

Date: _____

Name: _____ Date Of Birth: _____

Address: _____

Home Phone: _____ Business Phone: _____

Cell Phone: _____ E-mail: _____

Physician: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Your Health

1) Have you been under the care of a physician, dermatologist or other medical professional within the past year?
No ☐ Yes, ☐ explain: _____

2) Any recent surgery, including plastic surgery? ☐ No ☐ Yes, explain: _____
_____

3) Any skin cancer? ☐ No ☐ Yes, explain: _____

4) Have you had any piercings, tattoos, or permanent cosmetics? ☐ No ☐ Yes, If yes, where on your person?
_____

5) Have you ever had a body spa treatment before? ☐ No ☐ Yes, when: _____

6) Have you had any of these health conditions in the past or present?

(Please check all that apply and provide additional information in the space provided)

Cancer	☐	Headaches (chronic)	☐
Hormone imbalance	☐	Hepatitis	☐
Systemic disease	☐	Herpes	☐
High blood pressure	☐	Frequent cold sores	☐
Spinal injury	☐	Immune disorders	☐
Thyroid condition	☐	HIV/AIDS	☐
Hysterectomy	☐	Lupus	☐
Diabetes	☐	Metal bone pins or plates	☐
Heart problem	☐	Phlebitis, blood clots, poor circulation	☐
Varicose veins	☐	Blood clotting abnormalities	☐
Arthritis	☐	Psychological treatment	☐
Asthma	☐	Insomnia	☐
Eczema	☐	Keloid scarring	☐
Epilepsy	☐	Skin disease/skin lesions	☐
Seizure disorder	☐	Any active infection	☐
Fever blisters	☐		

7) Has your physician discussed concerns about raising your body temperature? ☐ No ☐ Yes

explain: _____
_____

Confidential Client Health History Form—continued

8) Do you smoke? ☐ No ☐ Yes

9) Do you follow a restricted diet? ☐No ☐Yes, specify: _____

10) Do you follow a regular exercise program?☐No ☐Yes

11) What is your stress level? High ☐ Medium ☐ Low ☐

List any medications you take regularly: _____

List any over the counter medications (including vitamins, herbal supplements, aspirin, etc.) you take regularly: _____

12) Do you use Retin-A, Renova, Adapalene Hydroxyl Acid, Deferin, Glycolic Acid, AHA, Salicylic Acid or Retinol/vitamin A derivative products? ☐ No ☐ Yes, describe: _____

13) Have you used any of these products in the last 3 months? ☐No ☐Yes

14) Have you used an acne medication? ☐No ☐ Yes, when? _____ Which drug?_____

15) Do you form thick or raised scars from cuts or burns? ☐ No ☐ Yes

16) Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? ☐ No ☐ Yes, describe: _____

List your daily consumption of: Water _____ Caffeine _____ Alcohol _____

17) Do you experience any problems sleeping? ☐No ☐Yes

18) How many hours do you typically sleep each night? _____

19) Do you wear contact lenses? ☐No ☐Yes

20) Have you been exposed to the sun or used a tanning bed in the last 48 hours? ☐No ☐ Yes

21) How frequently are you exposed to the sun or use a tanning bed? ☐Infrequently ☐Frequently ☐Regularly

22) Do you have any metal implants or wear a pacemaker? ☐ No ☐Yes

23) Have you ever experienced claustrophobia? ☐No ☐Yes

24) Do you suffer from sinus problems? ☐No ☐Yes

25) Have you ever had an adverse reaction after using any skin care product? (Please circle any that apply)

☐Rash ☐Irritation ☐Peeling ☐Sun Sensitivity ☐Breakout

26) Have you ever had an allergic reaction to any of the following? (Please **check** any that apply and explain)

☐Cosmetics ☐Medicine ☐Food ☐Animals ☐Sunscreens ☐Iodine ☐Pollen ☐AHAs

☐Fragrance ☐Shellfish ☐ Latex ☐Drugs ☐Other: _____

Continued ⇨

If yes, please explain: _____

Female Clients Only:

27) Are you taking oral contraceptives? ☐ No ☐ Yes, specify: _____

28) Any recent changes to or from your contraceptive treatment? ☐ No ☐ Yes, If so, what and when? _____
_____

_____

29) Are you pregnant or trying to become pregnant? ☐ No ☐ Yes

30) Are you lactating? ☐ No ☐ Yes

31) Any menopause problems? ☐ No ☐ Yes, specify: _____

Please use this space to complete answers where space was insufficient. (Please include the number of the question)

_____

_____

_____

_____

_____

_____

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. I am aware that it is my responsibility to inform the esthetician/skin care therapist of my current medical or health conditions and to update this history. The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof.

Client Signature: _____ Date:_____

Informed Client Consent Form

NAME _____ DATE of BIRTH _____

Although every precaution will be taken to ensure your safety and well-being before, during, and after your treatment/ procedure, please be aware of the following information and possible risks and indicate that you fully understand what to expect. Please initial:

_____ I hereby consent to and authorize the technician/esthetician to perform the following treatment/procedure: _____

_____ I voluntarily agree to undergo this treatment/procedure after the nature and purpose of this treatment/procedure has been explained to me, along with the risks and hazards involved.

_____ Although it is impossible to list every potential risk and complication, I have been informed of possible benefits, risks, and complications.

_____ I understand that it is imperative to my health and safety that I disclose all of the information requested in the Client Consultation/Health History form. I have cited all conditions and circumstances regarding my health history, allergies, and medications, supplements, or prescriptions being taken (orally and/or topically), and any past reactions to products or medications.

_____ I understand that no specific guarantees of the results can or have been made and that there is the possibility I may require additional treatments/procedures to obtain the expected results at an additional cost.

_____ I have read and understand all pre-treatment, post-treatment, and home care instructions. I understand the importance of following all instructions given to me. In the event that I have additional questions or concerns regarding my treatment or post-treatment care, I will consult the technician/esthetician immediately. I understand that if I choose to consult a physician, I do so at my own expense.

_____ I consent to “before-and-after” photographs and videos for the purpose of documentation, potential advertising, and promotional purposes.

I understand that if I have any concerns, I will address these with my technician/esthetician. I give permission to my technician/esthetician to perform the above treatment/procedure we have discussed and will hold him/her/them and his/her/their staff harmless and nameless from any liability that may result from this treatment/procedure. I understand my technician/esthetician will take every precaution to minimize or eliminate negative reactions as much as possible. 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 been provided sufficient opportunity for discussion and to have any questions answered. I understand the procedure and accept the risks. I do not hold the

technician/esthetician, whose signature appears below, responsible for any of my conditions that were present but not disclosed at the time of this procedure that may be affected by the treatment performed today.

Client Name (Printed) _____

Client Name (Signature)_____ Date _____

Technician/Esthetician _____ Date _____

Cancellation & Rescheduling Policy

We appreciate your business. So that we can best serve all our clients, please be advised of these policies.

ARRIVAL TIME

Please aim to arrive 10 minutes before your scheduled appointment time. If you arrive after your scheduled appointment time, it may not be possible to extend the time available for your booked service; if your service is shortened due to your late arrival, you may still be charged the full cost of the service.

LATE POLICY / NO SHOW

If you are late or do not show to your appointment, it may be canceled and charged as a full service.

CHANGING YOUR APPOINTMENT

48 hours' notice is required to reschedule or cancel a booked appointment, except in cases of contagious illness as described below. There will be a cancellation fee applied If you do not contact our office within 48hrs of your appointment. All deposits are non refundable and will be lost without a 48hr notice.

SICKNESS OR FAMILY EMERGENCY

If you, or another person in your household, has an infectious or contagious illness, please contact us as soon as possible to reschedule your appointment for a later date. There is no penalty or time frame required in this case, for your safety and that of other clients.

I agree to the policies described above.

Client Name _____

Client Signature _____ Date_____

Photograph & Video Release Form

I hereby grant permission to the rights of my image, likeness and sound of my voice as recorded on audio or video tape without payment or any other consideration. I understand that my image may be edited, copied, exhibited, published or distributed and waive the right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image or recording. I also understand that this material may be used in diverse educational settings within an unrestricted geographic area.

Photographic, audio or video recordings may be used for the following purposes:

- conference presentations
- educational presentations or courses
- informational presentations
- on-line educational courses
- educational videos

By signing this release I understand this permission signifies that photographic or video recordings of me may be electronically displayed via the Internet or in the public educational setting.

I will be consulted about the use of the photographs or video recording for any purpose other than those listed above.

There is no time limit on the validity of this release nor is there any geographic limitation on where these materials may be distributed.

This release applies to photographic, audio or video recordings collected as part of the sessions listed on this document only.

By signing this form I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material for educational purposes.

Full Name_____

Signature_____Date_____

If this release is obtained from a presenter under the age of 19, then the signature of that presenter's parent

or legal guardian is also required.

Parent's Signature_____ Date_____