simplicity LASER

Laser Services Treatment Record

Client Name: ________________________________ Skin Type: ___________ First Tx Date: ________________

N.A.M.E.S	Wavelengths
☐ **N:** Any **New** medications, illnesses, or allergies since you last treatment? ☐ **A:** Did you have any **Adverse** reactions from your last treatment? ☐ **M:** Are you on your **Menstrual** cycle or hormonal medications? ☐ **E**: Since your last treatment did you **Experience** a) reduction in hair growth or b) desired results from laser ☐ **S:** When were in the **Sun** or tanning last?	☐ Alexandrite ☐ ND:YAG

Date	NAMES	Laser Manf	Laser Model	Wavelength	TX #	TX Area	Spt Size	Fluence	MS	DCD/ Zimmer	Weeks	Clinical End Point (Redness & Swelling Observed)	Treatment Notes	Staff Sig.
										/		0 1 2 3 4 5		
										/		0 1 2 3 4 5		
										/		0 1 2 3 4 5		
										/		0 1 2 3 4 5		
										/		0 1 2 3 4 5		
										/		0 1 2 3 4 5		
										/		0 1 2 3 4 5		
										/		0 1 2 3 4 5		
										/		0 1 2 3 4 5		
										/		0 1 2 3 4 5		
										/		0 1 2 3 4 5		
										/		0 1 2 3 4 5		
										/		0 1 2 3 4 5		
										/		0 1 2 3 4 5		
										/		0 1 2 3 4 5		

Date	Sig	Treatment Notes

© Simplicity Laser 2015