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		
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