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SKINCARE TREATMENTS – CLIENT INFORMATION AND CONSENT

NAME_____PHONE _____

TREATMENT_____

SKIN CARE HISTORY

HAVE YOU EVER HAD A FACIAL TREATMENT OR CHEMICAL PEEL BEFORE? _____

WHICH OF THE FOLLOWING MOST CLOSELY DESCRIBES YOUR SKIN TYPE?

I	CREAMY COMPLEXION	ALWAYS BURNS EASILY, NEVER TANS.
II	LIGHT COMPLEXION	ALWAYS BURNS, MAY TAN SLIGHTLY.
III	LIGHT / MATTE COMPLEXION	BURNS MODERATELY, TANS GRADUALLY.
IV	MATTE COMPLEXION	SELDOM BURNS, ALWAYS TANS WELL.
V	BROWN COMPLEXION	RARELY BURNS, DEEP TAN.
VI	BLACK COMPLEXION	NEVER BURNS, DEEPLY PIGMENTED.

DO YOU HAVE ANY SPECIAL SKIN PROBLEMS OR CONCERNS? _____
ARE YOU EXPOSED TO THE SUN DAILY? _____

PLEASE CIRCLE ANY AREAS OF CONCERN YOU HAVE REGARDING YOUR SKIN:

BREAKOUTS / ACNE	BLACKHEADS / WHITEHEADS	EXCESSIVE OIL / SHINE
ROSACEA	BROKEN CAPILLARIES	REDNESS / RUDDINESS
SUNSPOT / BROWN SPOTS	UNEVEN SKIN TONE	SUN DAMAGE
WRINKLES / FINE LINES	DULL / DRY SKIN	FLAKY SKIN
DEHYDRATED SKIN	SENSITIVE SKIN	
EYES DARK CIRCLES	PUFFINESS	FINE LINES

PLEASE CIRCLE IF YOU HAVE EVER HAD AN **ALLERGIC REACTION** TO ANY OF THE FOLLOWING:

COSMETICS	MEDICINE	FOOD
ANIMALS	SUNSCREENS	POLLEN
AHAS	FRAGRANCE	

PLEASE INITIAL (PLEASE READ CAREFULLY)

_____ I AM NOT PREGNANT _____ I AM NOT ALLERGIC TO ASPIRIN
_____ I HAVE NOT RECEIVED RADIATION TREATMENTS
_____ I HAVE NOT USED GLYCOLIC ACID FOR 24 HRS
_____ I HAVE NOT USED RETINOL PRODUCTS FOR 72 HRS
_____ I HAVE NOT TAKEN ACCUTANE IN THE PAST YEAR
_____ I AGREE TO AVOID DIRECT SUN EXPOSURE FOR 2 WEEKS
_____ I AGREE TO NOTIFY DR/AESTHETICIAN OF ANY CONCERNS

_____ I AGREE NOT TO PICK, PEEL, OR SCRATCH THE SKIN
_____ I DO NOT HAVE ACTIVE COLD SORES
_____ I AGREE THERE MAY BE CRUSTING AND SHEDDING OF SKIN
_____ A PRIOR PATCH TEST HAS BEEN GIVEN TO ME TO RULE OUT ANY ALLERGIC TENDENCIES
_____ I AGREE NOT TO WAX FOR 7 DAYS PRE/POST-TREATMENTS
_____ I AGREE TO FOLLOW UP WITH SCHEDULED APPOINTMENT
_____ I AGREE NOT TO USE RETIN-A PRODUCTS 7 DAYS PRE/POST TREATMENTS

_____ARE YOU TAKING HORMONAL CONTRACEPTIVES? _____ NO ARE YOU NURSING?
_____ EXPERIENCING ANY MENOPAUSE PROBLEMS?
_____ ARE YOU UNDERGOING ANY HORMONE REPLACEMENT THERAPY OR CANCER TREATMENTS?
_____ ARE YOU DIABETIC _____DO YOU HAVE ANY HEART PROBLEM
_____ HYPERTENTION

PRECAUTIONS (PLEASE READ CAREFULLY)

THE TREATMENT YOU WILL RECEIVE IS A CLINICAL TREATMENT DESIGNED TO EXFOLIATE OR REMOVE THE OUTER LAYERS OF THE SKIN.

YOUR PARTICIPATION IN YOUR SKINCARE TREATMENTS WILL DETERMINE THE OUTCOME. IT IS IMPORTANT THAT YOU STRICTLY ADHERE TO YOUR HOME CARE PRODUCTS THAT YOUR AESTHETICIAN HAS RECOMMENDED.

NO GUARANTEE IS EXPRESSED OR IMPLIED AS TO THE PRECISE RESULTS, PEELING TIMES OR DISCOMFORT.

DURING THE TREATMENT, YOU MAY EXPERIENCE SOME TEMPORARY STINGING OR WARM FLUSHING. THIS WILL FADE WITHIN A FEW MINUTES. DURING THE NEXT FEW HOURS, YOU MAY EXPERIENCE SOME TIGHTENING OF THE SKIN, WHICH MAY LAST FOR SEVERAL DAYS.

FOR MOST PATIENTS, FLAKING BEGINS WITHIN 48 HOURS. IT IS IMPOSSIBLE TO PRE-DETERMINE HOW MUCH PEELING WILL OCCUR. THE SHEDDING PROCESS USUALLY SUBSIDES WITHIN 5-7 DAYS.

DEPENDING ON THE CLINICAL PEEL PERFORMED AND YOUR SKIN QUALITY, THE FOLLOWING REACTIONS MAY OCCUR IN SOME PATIENTS:

1) PROLONGED REDNESS, IRRITATION AND FLAKINESS 2) DRYNESS AND SENSITIVITY 3) SEVERE ALLERGIC REACTIONS IN RARE INSTANCES

I UNDERSTAND THIS CONSENT FORM AND HAVE ANSWERED EACH QUESTION TRUTHFULLY. THE TREATMENT WAS EXPLAINED TO ME IN DETAIL.THE BENEFITS OF WHAT I CAN REALISTICALLY EXPECT TO SEE FROM MY CLINICAL PEEL HAVE BEEN FULLY EXPLAINED TO ME.

I UNDERSTAND THAT WITHHOLDING INFORMATION FROM MY SKIN CARE THERAPIST MAY RESULT IN CONTRAINDICATIONS OR SKIN IRRITATION FROM TREATMENTS RECEIVED. THE SKIN CARE TREATMENTS I RECEIVE AT EVOLVE ARE VOLUNTARY AND I RELEASE EVOLVE FROM LIABILITY AND ASSUME FULL RESPONSIBILITY THEREOF

SIGNATURE _____ DATE _____