CLIENT MEDICAL INFORMATION

PERSONAL INFORMATION			
Name:		Date of Birth:	
Address:		Email:	
Cell Phone:		Secondary Phone:	

HEALTH QUESTIONNAIRE	
Existing or recent illness:	Details:
Hospitalization / surgery:	Details:
Medication intolerance:	Details:
Aesthetic procedures in the treatment:	Details:

MEDICAL QUESTIONNAIRE

Please inform Esthetician prior to treatment if you have any of the following conditions that may make you unsuitable for LASER Hair Removal Treatments.

In order to provide care that is both safe and effective please review the following conditions. If any of the following conditions apply to you, Laser Hair Removal would not be advised. A doctors note may be required to proceed with treatment.

☐ Pregnancy or nursing	☐ Current or history of cancer, especially skin cancer or pre-malignant moles
☐ Impaired immune system due to immunosuppressive diseases such as AIDS and HIV, or use of immunosuppressive medication	☐ Poorly controlled endocrine disorders such as diabetes or thyroid dysfunction or polycystic ovaries
☐ A history of diseases stimulated by heat, such as recurrent Herpes Simplex in the treatment area (may be treated following prophylactic regimen)	☐ Any active skin condition in the treatment area, such as sores, psoriasis, eczema, dermatitis and rash
☐ History of skin disorders such as keloid scarring, abnormal wound healing as well as very dry, cracked, ulcerated, infected and fragile skin	☐ Tattoos and/or permanent make-up
☐ Use of Isotretinoin (Accutane®) within six (6) months prior to treatment	☐ Sunburned or freshly tanned skin
☐ Virtiligo (loss of pigmentation)	

This form is designed to give you the information you require to make an informed choice of whether or not to undergo treatment with DIOLAZE/DIOLAZEXL technology. If you have any questions before your treatment, please feel free to ask.

Please check (✓) next to each point:

- ☐ I hereby authorize the certified Laser Specialist at Hand & Stone Massage and Facial Spa to perform the DIOLAZE/ DIOLAZEXL procedure.
- ☐ The Laser Specialist has reviewed my medical history and found me to be eligible for treatment.
- ☐ I have received the following information about the technology:
  - ☐ DIOLAZE/DIOLAZEXL is a non-invasive technology that utilizes Diode laser, for hair removal with highest speed, the best skin cooling system for hairs of dark blond-black colour
  - ☐ No complete clearance is guaranteed
  - ☐ Individual results vary depending on hair colour, coarseness, density and skin tone
  - ☐ There may be some discomfort and transient redness and/or swelling associated with treatment
  - ☐ There is a small risk of adverse reactions

- [x] I understand that taking the treatment course is my choice and that I am free to withdraw at any time, without giving any reason.
- [ ] I was told about the possible side effects of the treatment including: local pain, skin redness (erythema), swelling (edema), damage to the natural skin texture (crust, blister, burn), change of pigmentation (hyper- or hypo-pigmentation) and scaring. Although these effects are rare and expected to be temporary, any adverse reaction should be reported immediately.
- [ ] I understand that I have to comply with treatment schedule, otherwise results may be compromised.
- [ ] I recognize that during the course of the procedure unforeseen conditions may necessitate different procedures than this above and I authorize the Laser Specialist at Hand & Stone Massage and Facial Spa to perform such other procedures if they find them professionally desired.
- [ ] I understand that not everyone is a candidate for this treatment and results may vary therefore, there is no guarantee as to the results that may be obtained.
- [ ] The procedures to be used to treat my conditions have been explained to me.
- [x] I have had sufficient opportunity to discuss my condition and treatment. I believe I have adequate knowledge upon which to base an informed consent.
- [x] Any questions I may have asked have been answered to my satisfaction.
- [ ] I authorize before, during and after the procedure(s) the taking of photographs to be part of my patient profile that may be used for marketing purposes without disclosing my identity nor exposing my face.

Client Name *(Print)*: _____

Client Signature: _____

Laser Specialist Signature: _____ Date: _____

If I am unable to make a scheduled appointment, I agree to cancel the appointment 24 hours in advance by phone, unless I have an emergency. In this case I will call ASAP to reschedule my appointment. If I miss a scheduled appointment without giving 24 hours notice, I agree to pay the missed appointment fee that applies. ***Initial Here:*** _____

I understand that any illicit or sexually suggestive behaviour, remarks or advances made by me will result in the immediate termination of the session and I will be liable for payment of the scheduled service. Further, I understand that Hand & Stone Massage and Facial Spa reserves the right to refuse to administer services at their sole discretion. I have read and fully understand this form in its entirety. I hereby release the practitioners, Hand & Stone Massage and Facial Spa and their insurers, and their respective officers, directors, stockholders, successors, employees, franchisor and agents from all liability of any nature whatsoever, whether past, present, or future, for injury or damage which may occur to myself or my family as a result of my receiving laser hair removal services.

I understand that I may disrobe to my comfort level. Some laser services require the Esthetician to touch and treat sensitive areas such as breast tissue, genitals, buttocks and inner thighs. I acknowledge that I can withdraw from my service or alter my consent at any time. ***Initial Here:*** _____

I hereby state that the information I have provided is accurate and true.

_____ _____

Client Signature **Date**

Consent to Treatment of Minors: By my signature below, I authorize Hand & Stone Massage and Facial Spa to administer laser hair removal services to my minor child or dependent as they deem necessary or proper.

SIGNATURE: _____ ***DATE:*** _____

_____ _____

Esthetician Signature **Date**