

Zap! electrolysis & skin care

Name:

Today's Date:

Date of Birth:

Street Address:

City:

Zip:

Primary Phone: () -

Alternate Phone: () -

Cell Carrier (For Text Reminders):

E-Mail:

Occupation:

Referred By:

Check the areas you wish to be treated:

Abdomen	Buttocks	Feet / Toes	Nasal	Sternum
Arms	Cheeks	Hairline	Neck	Thighs
Back	Chest	Hands / Fingers	Nose	Underarms
Bikini	Chin	Legs	Shoulders	
Breasts	Ears	Lips (Lower)	Sideburns	
Bridge	Eyebrows	Lips (Upper)	Spine	

Hormone related questions - for females with hair growth on areas above in **Bold**:

What age did hair growth begin?

Regular menstrual cycle every days.

Check all that apply:

Acne	Fertility Problems	Irregular Menses
Eating Disorder	Hormone / Endocrine Disorder	Scalp Hair Loss
Family History of Similar Hair Growth	Hysterectomy or Menopause	Weight Loss / Gain

Are you pregnant? Yes No

Are you breastfeeding? Yes No

Have you ever noticed sudden growth of your hair? Yes No

When and where?

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Name:

Previous Hair Removal:

Electrolysis - First Treatment:

Last Treatment:

Was treatment successful? Yes No

Why was treatment discontinued?

Bleaching - How often?

Sugaring - How often?

Cutting - How often?

Threading - How often?

Depilatory - How often?

Tweezing - How often?

Laser - Last treatment:

Waxing - How often?

Shaving - How often?

Other:

Have you experienced sensitivity from any of these treatments:

Ingrown Hairs	Redness / Swelling
Pigmentation	Other
Pimples	

Please Explain:

Do you have allergies to:

Alcohol	Latex	Plants	Topical Anesthetics
Aspirin	Medicines	Soaps	Witch Hazel
Cosmetics	Metals (Nickel/Silver)	Sun	Other
Foods			

Please Explain:

Do you have Pre-Existing Skin Conditions such as:

Acne	Pigmentation	Telangiectasia
Growths	Rash	Other
Ingrowns	Scarring	

Please Explain:

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Name: _____

Do you now, or have you ever used:

Accutane	Skin Peels
Alpha Hydroxy	Other
Retin A	

Please Explain: _____

Check the following if you have ever had, or have been treated for the following conditions:

Asthma	Difficulty Healing	Herpes / Cold Sores	Pacemaker
Body Piercing	Epilepsy	High Blood Pressure	STD
Bruise Easily	Heart/Chest Pains	HIV	Tuberculosis
Chemo/Radiation	Hemophilia	Keloids	
Diabetes	Hepatitis	Metal Implants	

Please Explain: _____

Are you currently taking any medications, either prescribed or over the counter? Yes No

Please list reason for taking: _____

If you are unable to keep your appointment, please call and cancel as soon as possible. ***You will be charged for appointments that are cancelled less than 24 hours in advance.*** I am forced to do this as I have a limited number of available hours and a late cancellation will not enable me to utilize this time. Also, late arrivals will be charged for the full session.

Please initial that you have read and understand the above statement: _____

Date

Client Name (Print)

Signature of Client

Person authorized to consent for client
when client is a minor (Print)

Signature of person authorized to consent
for client when client is a minor

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Acknowledgment of Information

(please initial each paragraph and electronically sign at bottom of page)

I understand health history information is important to the Zap! Electrolysis & Skin Care in order to provide me with safe and effective treatments. I acknowledge all information given by me is accurate to the best of my knowledge and I agree to update my health history assessment whenever there are changes.

initial here _____

I understand that a series of treatments over usually 12-18 months (but possibly longer) is necessary to achieve permanent hair removal based on my previous temporary methods of hair removal, the science of electrology, and my individual physiological factors.

initial here _____

I have been advised of the post-treatment healing process, the possible risks related to treatment, I agree to follow all aftercare instructions and to notify the Zap! Electrolysis & Skin Care of any concerns or difficulty in healing. Further, I will not hold Zap! Electrolysis & Skin Care or Tina Reynolds liable for any omissions or post-treatment reactions.

initial here _____

I authorize Zap! Electrolysis & Skin Care to take and maintain photographs for the purpose of personal records, case history, training and references.

initial here _____

I ACKNOWLEDGE THAT ZAP! ELECTROLYSIS & SKIN CARE HAS A FULL 24-HOUR CANCELLATION POLICY, AND I AGREE TO PAY IN FULL FOR ANY MISSED OR LAST MINUTE CANCELLED APPOINTMENTS. FURTHERMORE, I UNDERSTAND THAT IF I ARRIVE LATE FOR MY APPOINTMENT, MY SESSION WILL STILL CONCLUDE ON TIME WHILE THE FEE REMAINS THE SAME.

initial here _____

Date

Client Name (Print)

Signature of Client

Person authorized to consent for client when client is a minor (Print)

Signature of person authorized to consent for client when client is a minor