Zap! ELECTROLYSIS & SKIN CARE

Name:

Today's Date: Date of Birth:

Street Address: City: Zip:

Primary Phone: ( ) - Alternate Phone: ( ) -

Cell Carrier (For Text Reminders): <SELECT> 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 Date: Last Treatment Date:

Was treatment successful? Yes ☐ No ☐

Why was treatment discontinued?

Bleaching - How often? Never

Cutting - How often? Never

Depilatory - How often? Never

Laser - Last treatment Date:

Shaving - How often? Never

Sugaring - How often? Never

Threading - How often? Never

Tweezing - How often? Never

Waxing - How often? Never

Other:

Have you experienced sensitivity from any of these treatments:

☐ Ingrown Hairs
☐ Pigmentation
☐ Pimples
☐ Redness / Swelling
☐ Other

Please Explain:

Do you have allergies to:

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

Please Explain:

Do you have Pre-Existing Skin Conditions such as:

☐ Acne
☐ Growths
☐ Ingrowns
☐ Pigmentation
☐ Rash
☐ Scarring
☐ Telangiectasia
☐ Other

Please Explain:

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Name:

Do you now, or have you ever used:

- ☐ Accutane
- ☐ Alpha Hydroxy
- ☐ Retin A
- ☐ Skin Peels
- ☐ Other

Please Explain:

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

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

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)

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

_____
Signature of Client

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

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)

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

_____
Signature of Client

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