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| **Client Name : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_**  **Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PostCode: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Phone: (Home)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Work) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Please indicate if you currently have any of the following conditions:**   |  |  |  | | --- | --- | --- | | Skin Cancer | History of allergies | Active Acne | | Unidentified skin lesions | Allergy to latex | Rosacea | | Eczema/Dermatitis | Recent injury or surgery to area | Inflamed or painful areas of skin | | Diabetes | Loss of skin sensation | Hypersensitive skin | | Metal implants in body/piercings | Metal dental fittings | Epilepsy | | Heart conditions/Pacemaker | Migraines | Pregnancy |   **Are you currently under medical care or supervision for any condition? Yes / No**  If Yes, please detail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Please list any current medications you take: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Have you ever taken RoAccutane: Yes / No If Yes, please state when (year) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Have you ever had a Cold Sore: Yes / No If Yes, where do they appear? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Do you use any of the following products on your skin? (please circle)**  AHA/BHA/fruit acids Retinol/Vitamin A Acne Treatment products Prescription products (by Doctor)  **In the last 4 weeks, have you received: (please circle)**  **Chemical Peel Dermal filler injections Electrolysis IPL/Laser treatment Muscle relaxant injections Waxing** |
| **­Please describe your current skin care products/routine:**  Cleanser:  Moisturiser:  Other treatments (exfoliant, mask, serums, eye cream):  Sun protection: |
| **Lifestyle factors that influence skin condition** |
| How much water do you drink daily? How much Caffeine? |
| Do you smoke? Yes / No Weekly alcohol intake? |
| How would you rate your diet? Excellent Very Good Good Average Poor Very Poor |
| How would you describe your general health? Excellent Very Good Good Average Poor Very Poor |
| Sun exposure frequency: Never Rarely Sometimes Fairly Often Regularly Frequently |
| What concerns do you have about your skin? |
| I declare that the information provided is a correct and accurate assessment of my current state of health.  Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_  **If aged under 18 years, parental/guardian signature is required**  Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  All information provided is for the sole purpose of enabling us to treat you safely. All information is strictly confidential to protect your privacy.  **Consent for Microdermabrasion Treatment**  I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ understand:   1. The efficacy of the treatment varies from individual to individual and I understand that no guarantee is issued as to the results I will achieve. 2. In order to achieve the best possible results, a course of treatments will be required. I also understand that individuals vary in the total number of treatments required and that other treatments may be recommended to assist in achieving optimal results. 3. I understand that I must give staff all the relevant medical details prior to each treatment, and that the information I have provided on the Consultation form is correct and accurate to the best of my knowledge. 4. A test patch may be necessary before commencing treatment. 5. Following treatment, the skin may appear red and a sensation of sensitivity may be present. In the following 2-3 days, some flaking and/or tightness/puffiness may be evident. These side effects may take several days to resolve, but are considered to be normal responses. 6. Following treatment, I will be given post-treatment instructions, which I agree to follow. Strict adherence to these instructions is necessary in order to achieve the best results and avoid adverse effects. 7. There is a low risk of minor grazing or skin damage occurring. If this does occur, it may result in temporary hyperpigmentation or hypopigmentation (darkening or lightening) of the skin. While these reactions are not common, there is a possibility that they can occur. These reactions normally resolve with time. 8. I understand that it is my responsibility prior to each treatment undertaken that I inform the operator of any changes in medical status, including medications I am taking, or other treatments which I have had. 9. Microdermabrasion may temporarily increase the skins sensitivity to sun exposure. I have been advised to avoid sun exposure to the treated area as much as practicably possible, and I understand that I should use a high protection sunscreen on the treatment area every day, to avoid pigmentation disorders and other UV related damage.   This authorization is given for the purpose of facilitation of my care and shall supersede all previous authorizations and/or agreements executed by me. My signature certifies that I understand the goals, limitations, and possible complications of Microdermabrasion treatments, and that I wish to proceed with treatment. I have had the opportunity to ask questions about the procedure and have had my questions answered to my satisfaction.  Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_  **If aged under 18 years, parental/guardian signature is required**  Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Therapist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |