

  
**6860 South Yosemite Court**  
**Centennial, CO 80112**  
**720-838-9075**

**In order for provide the most appropriate Laser Hair Removal Treatment, we need you to complete the following questionnaire. All information is confidential.**

**PERSONAL DATA**

Client Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Emergency Contact : \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

How were you referred to us: \_\_\_\_\_

Is it OK to mail and/or email promotions: Yes \_\_\_ No: \_\_\_

**Which of the following best describes your Skin Type? Please Circle what best describes you:**

- I. Always Burns, Never Tans
- II. Always Burns, Sometimes Tans
- III. Sometime Burns, Always Tans
- IV. Rarely Burns, Always Tans
- V. Brown to Dark Brown, Moderately Pigmented Skin
- VI. Dark Brown to Brownish Black Skin

**MEDICAL HISTORY**

Have you had "Tattoo Removal "? Yes \_\_\_ No: \_\_\_ If yes, where on your body: \_\_\_\_\_

Do you have a Tattoo in the area to be treated? Yes \_\_\_ No: \_\_\_ If yes, where \_\_\_\_\_

Are you currently under the care of a physician? : Yes: \_\_\_ No: \_\_\_ If Yes, for what: \_\_\_\_\_

**Do you have any of the following medical conditions: Please mark all that apply:**

Cancer: \_\_\_ Diabetes \_\_\_ High Blood Pressure \_\_\_ Herpes \_\_\_ Arthritis \_\_\_ HIV/ Aids \_\_\_

Frequent Cold Sores \_\_\_ Keloid Scarring \_\_\_ Skin Disease/ Skin Lesions \_\_\_ Seizure Disorder \_\_\_

Hepatitis \_\_\_ Hormone Imbalance \_\_\_ Thyroid Imbalance \_\_\_ Blood Clotting Abnormities \_\_\_

Any Active Infection \_\_\_ Acne \_\_\_ Botox \_\_\_ Hemorrhoids \_\_\_ Polycystic Ovary Disease \_\_\_

Heart Disease \_\_\_ Burns/Skin Graphs \_\_\_ Photo Induced Epilepsy \_\_\_ Photo Induced Seizures \_\_\_

Retinal Disease \_\_\_ **Skin Conditions:** Skin Cancer \_\_\_ Disease that causes blistering of the skin \_\_\_

Do you have any other health problems or Medical Conditions: \_\_\_\_\_

\_\_\_\_\_

**MEDICATIONS:**

What oral medications are you currently taking? : Birth Control \_\_\_ Hormones: \_\_\_ IUD \_\_\_ Mirena \_\_\_

Other Oral Medications, Please List: \_\_\_\_\_

Have you ever used Acutance in the past 6 Months? Yes: \_\_\_ No: \_\_\_

What topical creams are you currently using: Retin-A \_\_\_ Retinol \_\_\_ Differin \_\_\_ Tazorac \_\_\_

Alpha Hydroxy (AHA) \_\_\_ Beta Hydroxy \_\_\_ (If Yes we recommend waiting 4 weeks before starting your treatment)

Are you currently taking a Doxycycline or Tetracycline Antibiotic? Yes: \_\_\_ No: \_\_\_

What herbal or vitamin supplements are you currently taking? Please List: \_\_\_\_\_

**SUN, SKIN AND HAIR REMOVAL HISTORY**

Do you have a history of a persistent skin rash produced by prolonged or repeated exposure to moderately Intense Heat or Infrared Irritation? Yes \_\_\_ No: \_\_\_

Have you had a chemical peel or laser treatment in the past 3 weeks? Yes \_\_\_ No \_\_\_ Where? \_\_\_\_\_

Have you ever had Laser Hair Removal? Yes: \_\_\_ No: \_\_\_ If Yes, Where on your body? \_\_\_\_\_

How many treatments did you get on this area? \_\_\_\_\_

Have you waxed, tweezed or used Depilatories in the area to be treated in the past 6 weeks?: Yes \_\_\_ No \_\_\_

Are there any moles in the areas to be treated? Yes: \_\_\_ No: \_\_\_ If Yes, Where on the body: \_\_\_\_\_

Have you had recent tanning or sun exposure that has changed the color of your skin? Yes \_\_\_ No \_\_\_ (If Yes we recommend waiting 4 weeks before starting your treatment)

Do you have hyper-pigmentation (darkening of the skin) or hypo-pigmentation (whitening of the skin)?

Yes \_\_\_ No \_\_\_ If Yes, Please Describe: \_\_\_\_\_

Do you get ingrown hairs frequently? Yes: \_\_\_ No: \_\_\_ If Yes, Where on the body: \_\_\_\_\_

**FOR FEMALE CLIENTS**

Are you pregnant?: Yes \_\_\_ No \_\_\_

Do you plan on becoming pregnant? Yes \_\_\_ No \_\_\_

Are you breastfeeding? Yes \_\_\_ No \_\_\_

Are you currently in Pre- Menopause? Yes \_\_\_ No \_\_\_

Are you currently going through menopause? Yes \_\_\_ No \_\_\_

**I certify that the preceding data, medical history, medication and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician (Rachelle Stokes ) of my current medical or health conditions and to update this history upon every treatment / appointment. A current medical history is essential for the technician to execute appropriate treatment procedures.**

**Printed Name :** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Date;** \_\_\_\_\_

**Guardian Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



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Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

I authorize Rachelle Stokes (Hair To Bare South) to perform the treatments. The purpose of these treatments is to diminish or remove unwanted hair. The quantity of hair that will disappear will depend on the client's skin type, hair color, hair thickness, region to be treated, energy level or tolerance to pain, and hormonal level. The treatment plan requires more than one treatment and may produce permanent hair removal. A residue of hair may remain at the end of the treatment. Residual hair is typically 50% lighter and thinner. The total number of treatments will vary between individuals. On occasion, there are clients that do not respond to treatments. The treated hair should exfoliate or push out in approximately 2-3 weeks.

***We are unable to treat clients that are on ACCUTANE, RETINA, RETINOL and PHOTSENSITIZING (Sun sensitive) medications. If you are using any of the above you must wait 4 weeks after stopping before laser hair removal treatments can be done.***

***Clients using ANTICOAGULANTS should be noted.***

The following problems may occur with the hair removal treatment:

1. Tattoo Removal: If you have had tattoo removal anywhere on your body and do not inform the technician of this, blistering and infection can occur if the laser is applied to this area. It is very important to inform the technician each visit to ensure your safety.
2. Scarring: THE IPL system can create a bruising and a moderate burn or blister to the skin. For an efficient treatment, the power (joules) needs to be just below the blistering point, which means skin will be red, However slight, there is risk of scarring.
3. Hyperpigmentation (browning of the skin) and Hypopigmentation (whitening of the skin) have been noted after treatment, especially with a darker complexion. This usually resolves within weeks but it can take as long as 3-6 months in some cases. Permanent color change is a rare risk. If you have a lot of color in your skin, a skin lightening cream will be advised to reduce the melanin in your skin before the treatment. Avoiding sun exposure after the treatment is crucial to reduce the risk of color change.
4. Erythema (redness) and Edema (swelling) of the treated area may occur. Although this usually subsides within a few hours, it can last up to 7 days or longer. Irritation, itching, and /or mild burning sensation may or pain similar to a sun burn may occur within 48 hours of treatment.
5. Infection: Although infection following IPL treatment is unusual, bacterial, fungal and viral infections can occur. Herpes virus infection around the mouth and/or genitals can occur following an IPL treatment. This applies to individuals with a herpes virus infection. Should any type of infection occur, additional treatment, including antibiotics, might be necessary. *If you have a history of the herpes virus in the treated area we recommend preventive therapy.*
6. Burning: Laser Hair Removal can cause a burn to the treated area for known and unknown reasons, and I freely assume these risks and will not hold liable Hair To Bare South and/or any of its associates.

7. *Skin Tissue Pathology:* Energy directed at skin lesions may potentially vaporize the lesion. Laboratory examination of the tissue specimen may not be possible. *Only clearly benign pigmented lesions can be treated. Check with your doctor for clearance.*
8. *Allergic Reactions:* In rare cases, local allergies to tape or preservatives used in preparations have been reported. Systemic reactions (which are more serious) may result from prescription medicines. Allergic Reactions may require additional treatment.
9. *Photosensitive (sun sensitive) Medication:* You understand that if you are taking a medication that makes your skin sensitive to the sun, you are responsible to note these medication (s) and to inform the technician and wait at least 4 weeks before treatment can be done.
10. *Ingrown Hair(s):* I understand that if I do not exfoliate and extract ingrown hairs frequently after laser hair removal that the ingrown hair(s) can become damaged by laser hair removal and become infected or abscessed. This is caused because the ingrown hair cannot push itself outside of the body.
11. *Wear Sunscreen of SPF 25 or higher before and after treatment to protect your skin.*
12. *I understand that I may need multiple treatments for the desired outcome.*
13. *I understand the exposure of my eyes to light could harm my vision. I will keep the eye protection on at all times.*
14. *I have read and understand the Pre and Post Treatment instructions.* I agree to follow these instructions carefully. I understand that compliance with recommended Pre and Post Treatment guidelines is crucial for healing, preventing of scarring, hyperpigmentation, hypopigmentation, and other skin textural changes. Including: burning, blistering, itching, redness of this skin and/or red bumps.
15. *I understand that the treatments may involve risks of complication or injury from both known and unknown causes, and I freely assume these risks.* I have been informed of other treatment options and understand that I have the right to refuse treatment. With this in mind, I am choosing this non-invasive treatment for hair removal.
16. *No guarantee, warranty, or assurance has been made to me as to the results that may be obtained.* I am aware that follow up treatments are necessary for desired results. I understand that gradual results occur over several treatments.
17. *I understand that all services rendered to me are charged directly to me and that I am personally responsible for payment.*

### **ACKNOWLEDGEMENT**

The nature and purpose of treatment has been explained to me. I have read and understand this agreement. All of my questions regarding the treatment have been answered satisfactorily. I understand the treatment and accept the risks.

I consent to terms of this agreement. I certify that I am competent adult of at least 18 years of age. This informed consent form is freely and voluntarily executed and shall be binding upon me. I hereby release Rachelle Stokes and Hair To Bare South from all liabilities associated with the above indicated treatment.

Printed Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Printed Name: \_\_\_\_\_ Minor Treated: \_\_\_\_\_

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_