Confidential Case History Card Date:_____

Name:_____

Address:_____

City/State/Zip:_____

Email Address_____

Phone: _____ Text ? Y/N

Birthdate:_____ Age:_____ Gender:_____

Emergency Contact:_____Relationship:_____Ph No:_____

Areas you'd like treated:_____

Temporary Hair Removal Methods: (Circle) Tweezing Waxing Depilatory Creams Shaving

How often? _____

Have you had laser treatments?(circle) YES NO If so, when? _____

Electrolysis: Have you had it before?(circle) YES NO If so, when?_____

How long did you undergo treatment?_____How often? (ex: 30 min each wk) _____

Did you get the results you expected?_____

Health Conditions		
Diabetic/Insulin Resistant	Y or N	How do you control it?
Hepatitis	Y or N	Meds?
HIV/Aids	Y or N	Meds?
Acne	Y or N	Meds?
Blood Clotting Disorder	Y or N	
Pacemaker	Y or N	
Metal in your body	Y or N	Include piercings, IUD
Warts	Y or N	In Work area?
Circulatory Disorder?	Y or N	Describe:
Are you Pregnant?	Y or N	
Any allergies?	Y or N	Meds?
Do you menstrate?	Y or N	If no, Plz Explain
PCOS? Polycystic Ovarian Syndrome	Y or N	Doctor Diagnosed?
Have you had any cosmetic injections or peels recently? (Botox, dermal fillers, Juvaderm, chemical peels) We'll need to avoid those areas which have been treated.		
Any other health conditions we should be aware of?		

Confidential Case History Card Date:_____

MEDICATIONS THAT CAN CAUSE HAIR GROWTH		
Type	**Y or N**	**Please List**
Hormones	Y or N	
Birth Control	Y or N	
Blood Pressure Medication	Y or N	
Anti-Seizure Medication	Y or N	
Sterioids	Y or N	
Anti-Depressants	Y or N	

IMPORTANT INFORMATION- Signature is required for treatment

1. I have given an accurate health history and agree to update my information whenever there are changes.
2. I acknowledge I have the skin/health conditions indicated above and in any photos taken prior to treatment.
3. I understand electrolysis is a series of treatments and the time it takes will depend on my adhering to the recommended treatment schedule, my individual physiological factors, and the methods of hair removal used in the past.
4. I understand there will be a post-treatment healing process and there are possible risks related to treatment. (Ex: redness, swelling, small temporary pustules, crusting/scabbing, hyperpigmentation) I understand the practicioner has no way to predict exactly how my skin might react. I was given written aftercare instructions and I fully understand what to do so my skin has the best chance of healing without issue.
5. I understand the electrologist may take photos to document skin and hair conditions. These will remain confidential unless a release is signed.

Payment and Cancellation Policies.

1. Payment is Cash or Check only. Should you need to cancel your appointment, please do so no less than 24 hrs. before your scheduled start time. If there is no notification and you do not keep the appointment, you will be billed for the time.

_____ _____

Client Signature Date