

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 menstruate?	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	
Steroids	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 practitioner 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.

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