Dermalove Esthetics and Massage
2005 Fayette
NKC, MO 64116

GENERAL INFORMATION

Last Name: _____ **First Name:** _____

Address: _____
Street City State Zip

Phone: ( ) _____ **Email:** _____

Mobile Phone: ( ) _____

Date of Birth: _____ **Occupation:** _____

Sex: Male / Female

Emergency contact: _____ **Phone:** _____

***** PLEASE INITIAL THE FOLLOWING: DUE TO INSURANCE LIABILITY ONLY THE CLIENT IS ALLOWED IN THE TREATMENT ROOM DURING ANY PROCEDURE. CHILDREN UNDER THE AGE OF 16 ARE NOT ALLOWED TO BE LEFT UNATTENDED IN THE SPA AT ANY TIME. PLEASE MAKE ARRANGEMENTS FOR CHILD CARE PRIOR TO YOUR APPOINTMENT. THANK YOU.**

***** PAYMENTS FOR SERVICES MAY BE MADE WITH CASH, MASTERCARD, VISA, DISCOVER AND AMERICAN EXPRESS. Person checks are accepted but returned checks will be subject to a $25 returned check fee.**

*****Appointments canceled the day of the appointment or no shows are subject to a $25 fee or loss of treatments when prepaid.**

*****Reminders are made via text message unless another preference is otherwise specified**

INITIALS: _____

Please circle all esthetic and massage services you would be interested in:

Microdermabrasion	Photo Facials	Swedish Massage
Chemical Exfoliation/Peels	Spider Vein Reduction	Deep Tissue Massage
Laser Hair Reduction	Waxing	Hot Stone Massage
Skin Tightening	Botox	Pre-Natal Massage
	Eyelash Extension	

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MEDICAL HISTORY: Please check any of the following that apply:

Pacemake/defibrillator	_____	Keloid Scarring	_____
Metal Implants	_____	Endocrine disorders	_____
Current or History of Skin Cancer/pre-malignant moles	_____	Pregnancy or nursing	_____
Severe concurrent medical conditions (e.g. cardiac disorders)	_____	Active skin infection(e.g. eczema, psoriasis)	_____
Impaired immune system	_____	Diseases stimulated by heat(e.g. Herpes Simplex	_____
Diseases stimulated by light (e.g. Lupus, Porphyria, Epilepsy	_____	Any tattoos in treatement area?	_____
Photosensitivity/photo allergic reactions	_____	Recent Sun exposure? (last 2-4 weeks)	_____
Have you waxed, tweezed, used chemical dipilatories such as Nair or had needle epilation in the last 6 weeks on the area to be treated?	_____		

Please List **ALL** medications you are currently taking: _____

_____

_____

_____

SIGNATURE AND DATE: _____

The following is a list of medicatons that could potentially cause photosensitivity. This list is not exhaustive, if you feel a medication may be in question, it is advised that you contact your physician before beginning treatments. Please circle any that apply. Please disclose any medication changes BEFORE EACH treatment session.

ACNE MEDS
Isotretinoin (Accutane)
Tretinoin (Retin-A)

ANTICANCER MEDS
Chlorambucil
Cyclophosphamide
Dacarbazine
Fluorouacil
Mercaptopurine
Methotrexate
Procarbazine
Thioguanine
Vinblastine

ANTIDEPRESSANTS
Amitriptyline
Amoxapine
Clomipramine
Doxepin
Imipramine
Isocarboxazid
Maprotiline
Phenelzine
Protriptyline
Trazadone
Trimipramine

ANTIEPILEPTICS SEDATIVE, MUSCLE RELAXANT
Carbamazepine
Cyclobenzaprine
Diazepam
Meprobamate
Phenobarbitol
Phenytoin

ANTIHISTAMINES
Azatadine
Clemastine
Diphenhydramine
Terfenadine
Tripelennamine

ANTIHYPERTENSIVES
Captopril
Diltiazem
Methyldopa
Minoxidil
Nifedipine

ANTIMICROBIALS
Ciprofloxacin
Clofazimine
Dapsone
Demeclocycline
Doxycycline
Enoxacine
Flucytosine
Griseafulvin
ketoconazole
Lomefloxacine
Methacycline
Minocycline
Nalidixic acid
Norfloxacin
Ofloxacin
Oxytetracycline
Pyrazinamide
Sulfa drugs
(Bactrim, Septra tetracycline)

ANTIPARASITICS
Bithionol
Chloroquine
Pyruvinium
Pamoate
Quinine
Thiabendazole

ANTIPSYCHOTICS
Chlorpromazine
Chlorprothixene
Fluphenazine
Haloperidol
Perphenazine
Prochlorperazine
Promethazine
Thioridazine
Thiothixane
Trifluoperazine
Thioflupromazine
Trimeprazine

CARDIOVASCULAR
Amiodarone
Atenolol
Captopril
Diltiazem
Disopyramide
Nifedipine
Propranolol
Quindine gluconate
Quindine sulfate
Verpamil

DIURETICS
Acetazolaminde
Amiloride
Bendroflumethiazide
Benzthalazie
Chlorothiazide
Furosemide
Hydrochlorothiazide
Hydroflumethiazide
Methyclothiazide
Metalazone
Polythiazide
Quinethazone
Trichlormethia-zide

HYPOGLYCEMICS
Acetohexamide
Chlorpropamide
Glipizide
Tolazamide
Tolbutamide

NSAIDS
Diclofenac
Fenoprofen
Flurbiprofen
Indomethacin
Ketoprofen
Meclofenamate
Naproxen
Phenylbutazone
Piroxicam
Sulindac

OTHERS
Bergamot oil
Oils of Citron
Lavendar,lime
sandalwood
Benzocaine
Clofibrate
Oral contraceptives
Etretinate
Gold salts
Hexachlorophene
Lovastatin
St. John's Wort
Gmethylcoumarin (used perfumes ,lotions, etc)
Skin Care lines (containing Retin-A, Glycolic, Lactic or Salicylci acids)

SIGNATURE: _____

DATE: _____

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LASER HAIR REMOVAL, IPL, SKIN TIGHTENING AND LEG VEIN TREATMENT INFORMED CONSENT

PLEASE READ AND INITIAL THE FOLLOWING:

I Authorize Dermalove Massage and Esthetics to perform the Polaris LV procedure and any other measures which in their opinion may be necessary _____

I understand that the eMax is a device used for treatment of laser hair removal, IPL skin rejuvenation, skin tightening and reduction of leg veins and vascular lesions and that clinical results from treatments may vary. I understand there is a possibility of short-term effects such as reddening, mild blistering or scabbing, temporary bruising and temporary discoloration of the skin, as well as the possibility of rare side effects such as scarring and permanent discoloration. These effects have been fully explained to me

_____

Results may vary depending on individual factors, including medical history, skin type, patient compliance with pre/post treatment instructions, and individual response to treatment. _____

I understand that treatment by the eMax system involves a series of treatments and the fee structure has been fully explained to me. I understand that I am financially responsible for any and all services that I receive. Payment is due before services are rendered.

_____

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and I understand that no guarantee can be given as to the final result obtained. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so. _____

I confirm that I am not pregnant or nursing at this time, and that I have not taken Accutane within the last 6 months. I do not have a pacemaker or interman defibrillator. I do not have a history of keloid scarring, have not had a deep chemical or mechanical peeling within the last 2 weeks preceding treatment, and I do not have poorly controlled diabetes. _____

I consent to taking of photographs and authorize their anonymous use for the purposes of medical audit, education and promotion. _____

I certify that I have been given the opportunity to ask questions and that I have read an fully understand the contents of this consent form. _____.

Signature:_____ **Date:**_____

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PLEASE CAREFULLY READ AND INITIAL THE FOLLOWING:

1. Groupons and other internet coupons are for new clients only. The same offers are available for current clients through the business. _____
2. All packages expire 1 year from date of purchase. Groupons and other coupons for packages will expire 1 year from the date of the first treatment. _____
3. No call no shows for appointments will automatically result in loss of a prepaid treatment or a $25.00 fee. This fee must be paid online before another appointment can be booked. Appointments canceled with less than 24 hours may also be subject to the same fees. When appointments are canceled at the last minute, it makes it difficult to fill the time and results in a financial loss for the business. _____
4. If you are going to be late for an appointment please call or text. Due to time constraints clients who will be more than 15 minute late will be have to be rescheduled. If there is no call or no text and the client is more than 15 minutes late it will be counted as a no call no show.

   _____
5. Please do not use cell phones for calls, games or other media. This is a spa atmosphere and excess noise including conversations should be kept to a minimum please. _____
6. Children under the age of 16 are not allowed to be left unattended in the spa at any time.

   _____
7. If you are receiving laser or IPL treatments please note that tanning beds and sun exposure must be avoided for one month prior to and one month after treatments end as well as in between treatments. **TANNING TO THE TREATMENT AREA INCREASES THE INCIDENCE OF BURNING, BLISTERING AND PERMANENT SCARRING AND DISCOLORATION.**

   _____
8. Please notify the technician of any major medical changes, new diagnoses and medication changes before each treatment _____
9. Dermalove Esthetics and Massage accepts all major credit cards as well as personal checks. Please note any personal check that is returned will be charged a $25 returned check fee.

   _____

Signature: _____

Date: _____