infinity laser
LASER HAIR REMOVAL & SKIN REJUVENATION

CLIENT INFORMATION

Name: _____ Sex: M/F/T Today's Date: _____/_____/____

Address: _____ Start Date: _____/_____/____

City: _____ State: _____ Zip Code: _____ Birthdate: _____/_____/_____

Please circle best # for confirmations calls if you do not want a text reminder.

Home Phone: _____ Work Phone: _____ Cell Phone & Phone provider: _____

AT&T, Sprint, Verizon, T-Mobile, Alltel, Other:_____

Primary Email: _____ Alternate Email for Promotions (if different)_____

Emergency Contact & Relationship: _____ Phone: _____

How did you hear about us? ☐ Referral (list names)* 1st _____ 2nd _____

Please indicate: ☐Google ☐Yahoo ☐Yelp ☐Magazine ☐YP ☐Charity Auction Other: _____

With INFINITY's Referral Reward Program, a $25 Reward will be mailed to the person(s) listed above, once you have completed your first treatment.

Laser Hair Removal: Check all the areas you are concerned about and circle the ones you are interested in treating now.

☐ Upper Lip	☐ Underarms	☐ Navel	☐ Chest
☐ Chin	☐ Forearms	☐ Lower Legs	☐ Abdomen
☐ Full Face	☐ Full Arms	☐ Thighs	☐ Nose/Ears
☐ Sideburns	☐ Fingers/Hands	☐ Full Legs	☐ Buttocks
☐ Neckline ~Front or Back	☐ Bikini - Standard	☐ Toes/Feet	☐ Pelvic Region
☐ Eyebrows	☐ Bikini - Extended	☐ Full Back & Shoulders	☐ Other_____
☐ Areola	☐ Bikini - Full	☐ Partial Back	☐ Other_____

What color is the hair in the areas you want to be treated? gray blonde red light brown medium brown dark brown black

Select the ONE description that would describe your skin if you were exposed to strong sun with no sun block: (see attachment)

I. Always burn, never tan
II. Always burns, sometimes tan
III. Sometimes burns, tans average
IV. Rarely burns, tans with ease
V. Brown, moderately pigmented, tans well
VI. Black, deeply pigmented, never burns

Skin Rejuvenation: Do you have any concerns about ☐Wrinkles/Fine Lines ☐Acne ☐Acne/Facial Scars ☐Enlarged Pores ☐Melasma ☐Sun Damage ☐Age Spots ☐Skin Texture/Tone ☐Sagging Skin ☐Broken Capillaries ☐Rosacea
Please check any skin services you are interested in learning more about ☐Complimentary Skin Analysis ☐SkinCeuticals ☐Dermaplaning ☐Microdermabrasion ☐Chemical Peels ☐Botox ☐Fillers ☐Radio Frequency Skin Rejuvenation ☐ IPL

PERSONAL HISTORY

Have you ever had laser hair removal? ☐Yes ☐No
Have you used any of the following hair removal methods in the past six weeks? ☐Yes ☐No
☐Laser ☐ Shaving ☐Waxing ☐Electrolysis ☐Tweezing ☐Threading ☐Depilatories (Nair, etc.)
Have you had any recent prolonged sun exposure (natural or tanning bed) that changed the natural color of your skin? ☐Yes ☐No
Have you recently used any self-tanning lotions or spray tan treatments in the past two weeks? ☐Yes ☐No
Do you form thick or raised scars from cuts or burns? ☐Yes ☐No
Do you have Hyper pigmentation (darkening of the skin) or Hypo pigmentation (lightening of the skin) or marks after physical trauma? If yes, please describe _____ ☐Yes ☐No

Have you had any recent surgery, including plastic surgery? ☐Yes ☐No Explain: _____

Do you have a history of skin cancer? ☐Yes ☐No Explain: _____
Do you follow a restricted diet? ☐Yes ☐No Explain: _____
Do you follow a regular exercise program? ☐Yes ☐No
What is your stress level? ☐High ☐Medium ☐Low

MEDICAL HISTORY

Do you have any of the following medical conditions? (Please check to the left)

□Arthritis □Cancer □Diabetes □High Blood Pressure □Frequent Cold Sores □Herpes Simplex I □Herpes Simplex II □HIV/AIDS

□Keloid Scarring □Skin Disease/Skin Lesions □Seizure Disorder □Hepatitis □Hormone Imbalance □Thyroid imbalance □PCOS

□Blood clotting abnormalities □Any active infections □ Other (list) _____

Are you currently under the care of a dermatologist or other medical professional? □Yes □No

Explain:_____

Do you have a history of erythema abigne, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation? □Yes □No

Do you have any photosensitive disorders: Lupus, Sun Rash, Vitaligo, Scleroderma? □Yes □No

Have you ever had an allergic reaction to any of the following? (Please check to the left)

□Food □Latex □Aspirin □Lidocaine □Hydrocortisone □Hydroquinone or skin bleaching creams □Aloe/Rubber □Cosmetics
□Sunscreens □Iodine □Pollen □AHAs □Fragrance □Shellfish □Drugs □Bee Stings □Other: _____

Have you ever had an adverse reaction to a skin care or laser treatment? □Yes □No Explain: _____

_____

MEDICATIONS

What oral medications are you presently taking? □Birth control pills □Hormones □ Other (please list)_____

_____

Are you on any mood altering or anti-depression medications? _____

Have you used Accutane in the past six months? □Yes □No

What topical medications or creams are you currently using? □Retin-A □Renova, □Adapalene □Hydroxyl Acid □Glycolic Acid □AHA
□Salicylic Acid or □Retinol/Vitamin A derivative products Describe:_____

What herbal supplements do you use regularly? _____

Please list any medications you are currently taking that may cause photosensitivity: (Consult Medication Chart)

_____

Please list any other medical and/or skin conditions we should know about: (Consult Medical Conditions Chart)

_____

Female Clients Only:

Are you pregnant or trying to become pregnant? □Yes □No
Are you currently breastfeeding? □Yes □No
Are you taking oral contraceptives? □Yes □No
Do you have any menopause problems? □Yes □No, Explain:_____

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician of my current medical or health condition and to update this history if anything changes before each subsequent treatment. A current medical history is essential for the technician to execute appropriate treatment procedures. The treatments I receive here are voluntary and I am aware that the results are not guaranteed. I release Infinity Laser Hair Removal & Skin Rejuvenation and/or my skin care professional from liability and assume full responsibility thereof.

Client Signature: _____ Date: _____

Laser Technician's Signature: _____ Date: _____