

## 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)\* 1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_  
 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.

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Upper Lip               | <input type="checkbox"/> Underarms         | <input type="checkbox"/> Navel                 | <input type="checkbox"/> Chest         |
| <input type="checkbox"/> Chin                    | <input type="checkbox"/> Forearms          | <input type="checkbox"/> Lower Legs            | <input type="checkbox"/> Abdomen       |
| <input type="checkbox"/> Full Face               | <input type="checkbox"/> Full Arms         | <input type="checkbox"/> Thighs                | <input type="checkbox"/> Nose/Ears     |
| <input type="checkbox"/> Sideburns               | <input type="checkbox"/> Fingers/Hands     | <input type="checkbox"/> Full Legs             | <input type="checkbox"/> Buttocks      |
| <input type="checkbox"/> Neckline ~Front or Back | <input type="checkbox"/> Bikini - Standard | <input type="checkbox"/> Toes/Feet             | <input type="checkbox"/> Pelvic Region |
| <input type="checkbox"/> Eyebrows                | <input type="checkbox"/> Bikini - Extended | <input type="checkbox"/> Full Back & Shoulders | <input type="checkbox"/> Other _____   |
| <input type="checkbox"/> Areola                  | <input type="checkbox"/> Bikini - Full     | <input type="checkbox"/> Partial Back          | <input type="checkbox"/> 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          | IV. Rarely burns, tans with ease          |
| II. Always burns, sometimes tan    | V. Brown, moderately pigmented, tans well |
| III. Sometimes burns, tans average | 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, Vitiligo, 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: \_\_\_\_\_