Client Consultation Form

NAME _____ DATE of BIRTH _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE _____ EMAIL _____

Sex: ☐ Female ☐ Male

How were you referred to us? _____

Occupation: _____ Does your job require that you work outdoors? ❍ No ❍ Yes

What would you like to achieve from your treatment today? _____

_____

YOUR SKIN CARE

1) Have you ever had a facial treatment before? ❍ No ❍ Yes, when? _____

2) Have you ever had a body spa treatment before? ❍ No ❍ Yes

   If yes, please specify when and what treatment: _____

3) Which of the following best describes your skin type? (Please check one)

☐	Type I	Fair skin tones—Always burns, never tans
☐	Type II	Light skin tones—Burns easily, tans slightly
☐	Type III	Fair to olive skin tones—Burns moderately, tans moderately
☐	Type IV	Light brown skin tones—Burns slightly, tans easily
☐	Type V	Dark brown skin tones—Rarely burns, tans easily
☐	Type VI	Dark brown to black skin tones—Never burns, tans easily

4) Do you have any special skin problems or concerns pertaining to your face or body? ❍ No ❍ Yes

   If yes, please specify: _____

5) Have you ever had chemicals peels, laser treatments, or microdermabrasion? ❍ No ❍ Yes

   In the last month? ❍ No ❍ Yes

6) Do you use Accutane, Retin-A, Renova, Adapalene Hydroxyl Acid or any other Retinol/vitamin A derivative products? ❍ No ❍ Yes

   If yes, please specify what and when last used: _____

7) Have you used acne medication? ❍ No ❍ Yes, when? _____ Which medication? _____

8) Have you experienced Botox, Restylane, or collagen injections? ❍ No ❍ Yes

   If yes, please specify: _____

Client Consultation Form—Continued

9) What skin care products are you currently using? (List brands if known)

Cleanser _____ Toner _____

Day Moisturizer _____ Night Moisturizer _____

Exfoliator _____ Mask _____

Eye Product _____ SPF/Sunscreen _____

Scrubs _____ Makeup Products _____

Soap _____ Shower Gels _____

Body Lotions _____ Other _____

10) Have you used any hair removal methods in the past six weeks? ❍ No ❍ Yes (Check all that apply)

☐ Shaving ☐ Waxing ☐ Electrolysis ☐ Plucking ☐ Tweezing
☐ Stringing ☐ Depilatories ☐ Other: _____

11) What areas of concern do you have regarding your: **Skin** (Check all that apply)

☐ Breakouts/acne ☐ Uneven skin tone ☐ Blackheads/whiteheads
☐ Sun damage ☐ Excessive oil/shine ☐ Wrinkles/fine lines
☐ Rosacea ☐ Dull/dry skin ☐ Broken capillaries
☐ Flaky skin ☐ Redness/ruddiness ☐ Dehydrated
☐ Sun/liver/brown spots ☐ Other: _____

Eyes (Check all that apply)

☐ Dehydrated ☐ Wrinkles ☐ Puffiness
☐ Dark circles ☐ Other: _____

Lips (Check all the apply)

☐ Dehydrated ☐ Cracked/chapped lips ☐ Other: _____

12) Have you ever had an allergic reaction to any of the following (Check all that apply)

If yes, please specify: _____

☐ Cosmetics ☐ AHAs ☐ Medication
☐ Fragrance ☐ Food ☐ Shellfish
☐ Animals ☐ Latex ☐ Sunscreens
☐ Drugs ☐ Iodine ☐ Pollen
☐ Other: _____

13) What SPF do you use on your face? _____ How often/when? _____

14) Have you recently used any self-tanning lotions, creams or treatments? ❍ No ❍ Yes

If yes, please specify: _____

15) Have you had any recent tanning bed or sun exposure that changed the color of your skin? ❍ No ❍ Yes

If yes, please specify: _____

LIFESTYLE

16) How many glasses of water do you drink per day? (Please check one)
☐ <1 glass ☐ 1-3 glasses ☐ 4-7 glasses ☐ 8+ glasses

17) How many caffeinated beverages (coffee, tea, soda, etc.) do you consume per day? (Please check one)
☐ None ☐ 1-2 drinks ☐ 3-5 drinks ☐ 6+ drinks

18) How many alcoholic beverages do you consume per week? (Please check one)
☐ I don't drink ☐ 1-3 drinks ☐ 4-7 drinks ☐ 8+ drinks

19) How many hours of sleep do you get per night? (Please check one)
☐ <3 hours ☐ 3-5 hours ☐ 6-8 hours ☐ 8-10 hours ☐ 10+ hours

20) Which foods do you consume on a regular basis?
☐ Fruits ☐ Vegetables ☐ Dairy/Eggs ☐ Cheese ☐ Poultry
☐ Fish ☐ Grains/Bread ☐ Processed Sugar ☐ Processed Meats

21) What does your daily commute look like?
☐ Car ☐ Bike ☐ Public Transport ☐ Walk ☐ I don't commute

22) How often do you travel on a plane?
☐ Never ☐ 1-2 times per year ☐ 1-2 times per quarter ☐ Every month ☐ Every week

23) How many hours do you spend in front of a screen or digital device?
☐ <3 hours ☐ 4-6 hours ☐ 7-9 hours ☐ 10-12 hours ☐ 12+ hours

24) Do you exercise on a regular basis? ❍ No ❍ Yes

25) Do you smoke cigarettes, vape, or consume other tobacco products? ❍ No ❍ Yes

26) What are your stress levels on a scale from 1 to 5 (1 = low stress, 5 = high stress)? _____

FEMALE CLIENTS

27) Are you taking oral contraceptives? ❍ No ❍ Yes

If yes, please specify: _____

28) Any recent changes to or from your contraceptive treatments? ❍ No ❍ Yes

If yes, please specify what and when: _____

29) Are you pregnant or trying to become pregnant? ❍ No ❍ Yes

30) Are you experiencing any menopausal symptoms? ❍ No ❍ Yes

If yes, please specify: _____

31) Are you undergoing any hormone replacement therapy treatments? ❍ No ❍ Yes

If yes, please specify: _____

MALE CLIENTS

32) Do you experience irritation from shaving? ❍ No ❍ Yes

If yes, please specify: _____

33) Do you experience ingrown hairs as a result of hair removal? ❍ No ❍ Yes

FUTURE APPOINTMENTS/CONTACT

May I call you at the provided phone number to confirm future appointments? ❍ No ❍ Yes

May I contact you via mail/email about future promotions and news? ❍ No ❍ Yes

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. The treatments I receive here are voluntary and I release this institution and/or the technician/esthetician/skin care professional from liability and assume full responsibility thereof.

Client Name (Printed): _____

Client Name (Signature): _____ Date: _____

INFORMED CLIENT CONSENT FORM

NAME _____ DATE of BIRTH _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE _____ EMAIL _____

Although every precaution will be taken to ensure your safety and well-being before, during, and after your treatment/procedure, please be aware of the following information and possible risks and indicate that you fully understand what to expect. Please initial:

_____ I hereby consent to and authorize the technician/esthetician to perform the following treatment/procedure: _____

_____ I voluntarily agree to undergo this treatment/procedure after the nature and purpose of this treatment/procedure has been explained to me, along with the risks and hazards involved.

_____ Although it is impossible to list every potential risk and complication, I have been informed of possible benefits, risks, and complications.

_____ I understand that it is imperative to my health and safety that I disclose all of the information requested in the Client Consultation/Health History form. I have cited all conditions and circumstances regarding my health history, allergies, and medications, supplements, or prescriptions being taken (orally and/or topically), and any past reactions to products or medications.

_____ I understand that no specific guarantees of the results can or have been made and that there is the possibility I may require additional treatments/procedures to obtain the expected results at an additional cost.

_____ I have read and understand all pre-treatment, post-treatment, and home care instructions. I understand the importance of following all instructions given to me. In the event that I have additional questions or concerns regarding my treatment or post-treatment care, I will consult the technician/esthetician immediately. I understand that if I choose to consult a physician, I do so at my own expense.

_____ I consent to "before-and-after" photographs for the purpose of documentation, potential advertising, and promotional purposes.

I understand that if I have any concerns, I will address these with my technician/esthetician. I give permission to my technician/esthetician to perform the above treatment/procedure we have discussed and will hold him/her/them and his/her/their staff harmless and nameless from any liability that may result from this treatment/procedure. I understand my technician/esthetician will take every precaution to minimize or eliminate negative reactions as much as possible. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read and fully understand the above paragraphs and that I have been provided sufficient opportunity for discussion and to have any questions answered. I understand the procedure and accept the risks. I do not hold the technician/esthetician, whose signature appears below, responsible for any of my conditions that were present but not disclosed at the time of this procedure that may be affected by the treatment performed today.

Client Name (Printed) _____

Client Name (Signature)_____ Date _____

Technician/Esthetician _____ Date _____

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the healthcare provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the healthcare provider and/or other licensed healthcare providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the healthcare provider, including those working at the healthcare provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the healthcare provider, and/or the healthcare provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) and provide National Arbitration and Mediation ("NAM") with the party arbitrator's contact information within thirty days of the date Respondent files its initial responsive pleading. A third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties from a list of arbitrators supplied by National Arbitration and Mediation ("NAM") within thirty days thereafter. The list supplied by NAM shall be a list of between 5 and 10 arbitrators, depending upon availability. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's equal share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that, where not in conflict with this agreement, the Healthcare Malpractice Dispute Resolution Rules and Procedures of NAM shall govern any arbitration conducted pursuant to this Arbitration Agreement. A copy of NAM rules are available on its website at https://www.namadr.com or by calling 1-800-358-2550 to request a copy of the rules.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the healthcare provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

Patient Name (print): _____ Signature: _____ Date: _____

Parent or Guardian (print): _____ Signature: _____ Date: _____

Office Name: _____ Signature: _____ Date: _____

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE