



Welcome, and thank you for choosing Laser 1. Please complete the following questionnaire:
The answers you provide will help us to care for you and your aesthetic needs better.

Personal Information

Full Name _____

How would you like to be addressed? _____

Address _____ Apt # _____

City _____ State _____ Zip Code _____

Best phone number to be reached at ____ (____) _____

Alternate phone number ____ (____) _____

E-mail address _____

Birthday _____

Would you like a reminder call 48 hours prior to your appointment? Yes No

Would you like to be on our mailing list to receive promotional offers? Yes No

How did you hear about us? _____

For our female clients

Are you pregnant or trying to become pregnant? Yes No

Are you breast feeding? Yes No

Medical History

Are you currently under the care of a Physician Yes No

Doctors Name _____ Phone # _____

Current Medications

YES NO

Have you ever used Accutane?
If so, when was your last dose? _____

Have you ever had gold therapy?

Are you currently taking birth control pills, hormones or any other medications on our photosensitivity list on a daily basis?

Are you on any mood altering or antidepressant medication?

Are you using any topical medications on the areas to be treated such as Retin-A, Renova, Differin or Tazorac?

Current medications *continued*

Please list all medications, including vitamins or herbal supplements that you are currently taking.

Allergies *(Including Topical Medications and Preparations)*

Please list all known drug allergies: _____

Have you ever experienced an allergic reaction to Aloe Vera or Latex? Yes No

Do you have any of the following medical conditions?:

Please check all that apply

YES NO

- Heart Disease: Angina, Hypertension, Murmur, Pacemaker
- Lung Disease: Asthma, Emphysema, Sleep Disorder
- Neurologic Disease: Stroke, Seizure
- Neuromuscular Disease: Multiple Sclerosis, Myasthenia Gravis
- Liver Disease
- Kidney Disease
- Diabetes or Hypoglycemia
- Thyroid Disease / Imbalance
- Hormonal Imbalance
- Gastrointestinal Disease
- Cancer
- Bleeding Disorder or Blood Clots
- OB/Gyn Issues: Pregnancy or Breast Feeding, Polycystic Ovarian Syndrome
- Skin Disease: Psoriasis, Excema, Rosacea, Erythema Ab Igne
- Infectious Disease: Herpes, HIV/AIDS
- Tobacco, Alcohol or Recreational Drug Use

If you have any other health problem or medical conditions not mentioned above, please explain _____

Aesthetic History

YES NO

- Previous laser hair removal
- Recent sun exposure or tanning
- Currently using self-tanning lotions or treatments
- History of hyperpigmentation (darkening of the skin) after injury
- History of hypopigmentation (lightening of the skin) after injury
- Do you form thick, raised scars (keloids) after injury

If yes to any of the above, please explain: _____



Laser Hair Removal

Informed Consent

Client's Name _____ Date _____

Please initial lines 1-18; sign and date the bottom after all your questions have been answered.

1. _____ The purpose of this procedure is to permanently reduce unwanted hair. The procedure requires more than one treatment and may produce permanent hair removal.
2. _____ The average person needs between 4 & 8 treatments for all areas of the body, including the face. The majority of our clients see excellent results, but there are a few people who do not respond to the treatments at all. Certain people, due to genetics or medical conditions that cause hair growth, may require ongoing treatments.
3. _____ Dark hair responds best. Red, white, blonde, and gray hair may not respond at all.
4. _____ Test spots are sometimes necessary to determine the proper laser settings.
5. _____ For best results, adhere to the recommended treatment schedule.
6. _____ Avoidance of sun exposure on the area to be treated is imperative, and the use of at least SPF 20 is necessary during the duration of your treatments.
7. _____ The sensation of the laser is best described as a rubber band snap.
8. _____ The treated hair appears to be growing for the first 5-15 days after a treatment. **THIS IS NOT NEW HAIR GROWTH**, but simply the old hair pushing itself out of the follicle.
9. _____ All lasers at Laser 1 are FDA approved for permanent hair reduction.
10. _____ I understand that exposure of my eyes to the laser light could harm my vision. I must keep the eye protection goggles on at all times.
11. _____ However slight, **there is a risk of scarring.**
12. _____ **Bleeding:** Pinpoint bleeding is rare but can occur following treatment procedures. Should bleeding occur, additional treatments may be necessary.
13. _____ **Allergic Reactions:** In rare cases, local allergies to tape, preservatives used in cosmetics or topical preparations have been reported. Systemic reactions (which are more serious) may result from prescription medications.

14. _____ Guests in the laser room during treatments must comply with all safety precautions.
15. _____ **Short-term side effects may include reddening, mild burning, temporary Bruising or blistering. Hyper-pigmentation (darkening) and hypo-pigmentation (lightening)** have also been noted after treatment. These conditions usually resolve within 3-6 months, but permanent pigment change is a slight risk. Avoiding sun exposure before and after the treatment reduces the risk of pigmentation changes. Infection: although infection following treatment is unusual, bacterial, fungal and viral infections can occur. Herpes simplex virus infections around the mouth can occur following a treatment. This applies to both individuals with a past history of herpes simplex infections and individuals with no history of herpes simplex virus infections in the mouth area. We recommend a physician consultation before treatment for cold sore preventatives. Should any type of skin infection occur, additional treatments or medical antibiotics may be necessary.
16. _____ Compliance with the before and after care guidelines is crucial for healing, prevention of scarring and hyper-pigmentation.
17. _____ Occasionally, unforeseen mechanical problems may occur and your appointment may Need to be rescheduled. We will make every effort to notify you prior to your arrival at the office.
18. _____ All sales are final. Failure by patient to use purchased treatment shall not be grounds for a cash refund. For a period of up to one year, you may receive in house credit for any unused pre-paid services.

Acknowledgment:

My questions regarding laser hair reduction have been answered satisfactorily. I understand the procedure and accept the risks. I hereby release the laser technician, the staff, the medical director, this facility, and Body Well Therapies Inc. dba Laser 1, from all liabilities associated with the laser hair reduction procedure. I have received a copy of the client instructions and cancellation policy.

Client/Guardian _____ Date _____

Laser Technician _____ Date _____



NAME _____

DATE _____

FITZPATRICK SKIN TYPE ASSESSMENT

Genetic Disposition

Score	0	1	2	3	4
What is the color of your eyes?	<input type="checkbox"/> Light Blue / Light Green	<input type="checkbox"/> Blue / Green	<input type="checkbox"/> Hazel	<input type="checkbox"/> Dark Brown	<input type="checkbox"/> Brown / Black
What is your natural hair color?	<input type="checkbox"/> Sandy Red	<input type="checkbox"/> Blonde	<input type="checkbox"/> Chestnut/Dark Blonde	<input type="checkbox"/> Dark Brown	<input type="checkbox"/> Black
What is the color of your non-exposed skin?	<input type="checkbox"/> Reddish	<input type="checkbox"/> Very Pale	<input type="checkbox"/> Pale/with Beige Tint	<input type="checkbox"/> Light Brown	<input type="checkbox"/> Dark Brown
Do you have freckles?	<input type="checkbox"/> Many	<input type="checkbox"/> Several	<input type="checkbox"/> Few	<input type="checkbox"/> Incidental	<input type="checkbox"/> None

Reaction to Sun Exposure

Score	0	1	2	3	4	Total
What happens when over exposed to the sun?	<input type="checkbox"/> Redness / Blistering / Peeling	<input type="checkbox"/> Blistering / Peeling	<input type="checkbox"/> Burns, sometimes peels	<input type="checkbox"/> Rarely Burns	<input type="checkbox"/> Never Burns	
To what degree does your skin turn brown?	<input type="checkbox"/> Hardly / Not At All	<input type="checkbox"/> Light Color Tan	<input type="checkbox"/> Medium Tan	<input type="checkbox"/> Tans Easily	<input type="checkbox"/> Turn Dark Brown Quickly	
Do you turn brown within several hours after sun exposure?	<input type="checkbox"/> Never	<input type="checkbox"/> Seldom	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Often	<input type="checkbox"/> Always	
How does your face react to the sun?	<input type="checkbox"/> Very Sensitive	<input type="checkbox"/> Sensitive	<input type="checkbox"/> Normal	<input type="checkbox"/> Very Resistant	<input type="checkbox"/> No Problem	

Tanning Habits

Score	0	1	2	3	4	Total
When were you last exposed to the sun, tanning beds or creams?	<input type="checkbox"/> More Than 3 Months Ago	<input type="checkbox"/> 2 to 3 months	<input type="checkbox"/> 1 to 2 months	<input type="checkbox"/> Less Than 1 Month	<input type="checkbox"/> Less Than 2 Weeks	
Is the area to be treated exposed?	<input type="checkbox"/> Never	<input type="checkbox"/> Hardly Ever	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Often	<input type="checkbox"/> Always	

Do you have any of the following in your family heritage?

Total _____

- African American Relationship _____
- Latin American Relationship _____
- American Indian Relationship _____
- East Indian Relationship _____
- Asian Pacific Relationship _____
- Mediterranean Relationship _____

Summary

Total for Genetic Disposition _____

Total for Reaction to the Sun _____

Total for Tanning Habits _____

Skin Type Score _____

Skin Type Score	Skin Type
0 to 8	I
9 to 16	II
17 to 24	III
25 to 30	IV
31 to 34	V
35 and Over	VI

***Recently suntanned skin overrides the skin type score*

I have reviewed this assessment and agree with the analysis.

Signature _____ Date _____

Technician _____ Date _____