Accurate Electrolysis

Permanent Hair Removal

Today's Date: _____

Personal Information

Last Name: First Name: M.I. Sex: M or F

Address:

Preferred Phone Number: Is it OK to leave voicemails at this #? Yes or No

E-mail Address: Date of Birth: Age:

Emergency Contact: Contact Phone Number:

Referred By:

Area/s to be Treated: **Please Circle All that Apply**

Hairline	Cheeks/Sideburns	Back
Brows	Upper/Lower Lip	Forearms
Ears	Chest/Breasts	Upper/Lower Abdomen
Chin	Underarms	Feet/Toes
Throat/Jaw	Shoulders/Upper Arm	Hands/Fingers
Nape/Neck	Upper/Inner Thigh	Bikini
Lowers Legs	Other	

Temporary Hair Removal Methods:

☐ Razor freq._____ ☐ Scissors freq._____

☐ Bleach freq._____ ☐ Abrasives freq._____

☐ Wax freq._____ ☐ Depilatories freq._____

☐ Sugar freq._____ ☐ Threading freq._____

Other:_____

How often do you remove hair: Daily Weekly Monthly Rarely

Females Only:

☐ Regular Menstrual Cycle What Age Did Hair Growth Begin?

☐ Irregular Menstrual Cycle

Alternate Hair Removal Methods:

☐ Galvanic / Blend - # of Treatments:_____ ☐ Laser - # of Treatments:_____

☐ High Frequency - # of Treatments:_____ ☐ Other - # of Treatments:_____

Skin Type: Dry Combination Oily Dehydrated Moist Sensitive

Have you ever undergone:

☐ Vitamin A (retinoic acid) ☐ Accutane ☐ Gold Salts ☐ Laser

☐ Chemical Peel ☐ Microdermabrasion

Are you prone to:

☐ Keloids ☐ Moles ☐ Milias/Whiteheads ☐ Comedones/Blackheads ☐ Acne

☐ Skin Tags ☐ Hyper-Pigmentation / Pigment Problems ☐ Verruca/Warts

Skin reactions to previous hair removal methods:

☐ Folliculitis ☐ Pigmentation ☐ Pimples ☐ Scaring ☐ Redness

☐ Infections ☐ Ingrown Hairs ☐ Acne ☐ Swelling ☐ Other

Last Name: First Name: M.I. Sex: M or F

Medical Information:

Attending Physician Date of Last Physical: Contact Phone

Current Medications:

Past Medications (w/dates):

Any Hormone Problems:

Check all that apply:

- ☐ Hormones
- ☐ Natural Products
- ☐ Antibiotics
- ☐ Cortisone
- ☐ Oral Contraceptives
- ☐ Healing Problems
- ☐ Persistent Bleeding
- ☐ Anticoagulants
- ☐ Infectious Disease
- ☐ Contact Lenses
- ☐ High Blood Pressure
- ☐ Cold Sores
- ☐ Cardiovascular Disease
- ☐ Other
- ☐ Scars
- ☐ Arterial Disease
- ☐ Anti-inflammatories
- ☐ Nervous Disorders
- ☐ Menopause
- ☐ Thyroid
- ☐ Hemophilia
- ☐ Pregnancy
- ☐ Saline Implants
- ☐ Metal Implants
- ☐ Hormone Disorder
- ☐ Breathing Problems
- ☐ Dental Implants
- ☐ Hepatitis (A - B - C)
- ☐ Dental Implants
- ☐ Cancer/Remission
- ☐ Skin Cancer
- ☐ Metallic Inclusion
- ☐ Fertility Problems
- ☐ Sensibility Loss
- ☐ Poor Blood Circulation
- ☐ Pacemaker
- ☐ Hysterectomy
- ☐ Endocrine Disorder
- ☐ Tuberculosis
- ☐ Homeopathy
- ☐ Vitiligo
- ☐ AIDS
- ☐ Pregnant
- ☐ Diabetes
- ☐ Herpes
- ☐ Piercing
- ☐ Tattoo
- ☐ Razor
- ☐ Asthma
- ☐ I.U.D.
- ☐ Acne
- ☐ Epilepsy

Allergies:

- ☐ Latex
- ☐ Iodine
- ☐ Aloe
- ☐ Cosmetic Products
- ☐ Aspirin
- ☐ Metal
- ☐ Other _____

Acknowledgment of Information

I understand health information is important to the Electrologist in order to provide me with safe and effective electrology treatments. I acknowledge all information given by me is accurate to the best of my knowledge and I agree to update my health history assessment when-ever there are changes._____

Understand that a series of treatments is necessary to achieve permanent hair removal based on my previous temporary methods of hair removal, the science of electrology, and my individual physiological factors. _____

I have been advised of the post-treatment healing process; the possible risks related to treatment, I agree to follow all aftercare instructions and to notify the Electrologist of any concerns or difficulty in healing._____

I declare that I have answered to all the above questions to the best of my ability and I release this establishment, its manager and its employees of all responsibility concerning any damage or incident that may result from the treatment.

Signature: _____ Date: _____

Signature of Guardian for Minor: _____ Date: _____