Confidential Case History Card

Date ____________________

Name ____________________

Address ____________________

City/State/ZIP ____________________

Email address ____________________

Home phone ____________________ Cell # ____________________

■ **We communicate most often by text. May we text you?** ☐ **YES** ☐ **NO**

Birth date ____________________ Age ____________ Gender ____________

Emergency contact ____________________ Relationship ____________ Phone # ____________

Photo id# ____________________

How did you hear about us? ____________________

Areas you'd like treated ____________________

■ ***PAYMENT AND CANCELATION POLICIES—Your signature is required for treatment***

1. **Payment is cash or check only.**
2. Missed appointments or appointments canceled less than 24-hours in advance will be invoiced to you via PayPal invoice. Payment must be received before future appointments can be booked—no exceptions.
3. Returned checks for insufficient funds are assessed a $25 fee in addition to the check's face value. You will be invoiced via PayPal and payment must be received before future appointments can be booked—no exceptions.

■ ***IMPORTANT INFORMATION—Your signature is required for treatment***

1. I acknowledge I have the skin/health conditions indicated on this form and in any photos taken prior to treatment.
2. I understand electrolysis can produce skin effects such as redness, swelling, welts, small pustules, temporary scabbing/crusting, hyperpigmentation, bruising. I understand and acknowledge there is no way my practitioner can predict how my skin will react. I was given aftercare information detailing skin care procedures after treatment and I fully understand what to do and will follow the instructions so my skin has the best chance of healing without issue.
3. I understand that although electrolysis is permanent, it will take a series of treatments over a period of time to achieve permanence. I understand the success of my treatments will depend on my compliance with my treatment schedule, my pain tolerance level, inherited hair-growth patterns and any medications I'm taking or medical conditions I have, either known or unknown, that may affect hair growth.
4. I understand that photo documentation is sometimes taken of the area being treated to provide an accurate record of pre-existing conditions and hair growth extent. These photos will never be used for any purposes without my written permission.

■ ***My signature certifies that the health and medications information obtained from me is true and correct to the best of my knowledge, that I understand there may be unforeseen side effects from electrolysis treatments and that I have read, understand and agree to this office's payment and cancelation policies.***

Client signature ____________________ Date ____________

Parent/guardian's signature if under 18 years of age ____________________ Date ____________

Hair removal methods you currently use: ☐ None ☐ Tweezing ☐ Waxing/sugaring ☐ Depilatory creams ☐ Shaving ☐ Trimming

How long have you used this method? ______________________________

Have you had laser treatments? ☐ Yes ☐ No When was your last laser session? ______________________________

How many sessions did you have over what period of time? ______________________________

****ELECTROLYSIS:** Have you had electrolysis before? ☐ Yes ☐ No If yes, when was your last treatment? ______________________________

How long did you undergo treatment? ______________________________

How often? (ex: 15 minutes each week) ______________________________

Did you get the results you expected? ______________________________

■ ***Medications you take (these can cause or accelerate unwanted hair growth):***

Hormones (Ex: thyroid, estrogen, testosterone)....... ☐ Y ☐ N Please list______________________________

Anti-depressants/Anti-anxiety meds........................ ☐ Y ☐ N Please list______________________________

Steroids (Ex: cortisone, prednisone)........................ ☐ Y ☐ N Please list______________________________

Anti-seizure/Migraine meds .... ☐ Y ☐ N Please list______________________________

Blood pressure meds... ☐ Y ☐ N Please list______________________________

Birth control... ☐ Y ☐ N Please list______________________________

■ Prescription acne or anti-aging meds you take such as: Accutane, Retin-A, Avage, Tazorac, Differin (Adapalene) OTHER:

Please list all: ______________________________

■ Have you had any cosmetic injections or peels recently? (Ex: Botox, Juvaderm, chemical peels) When? ______________________________

Please list all and what part of your face/body. It's important we AVOID that area: ______________________________

■ ***Health conditions:***

Diabetic/Insulin resistant...................................... ☐ Y ☐ N How do you control it? ______________________________

Hepatitis .... ☐ Y ☐ N How do you control it? ______________________________

HIV/AIDS... ☐ Y ☐ N How do you control it? ______________________________

Blood clotting disorder.. ☐ Y ☐ N

Pacemaker .... ☐ Y ☐ N

Any metal in your body .... ☐ Y ☐ N Where? Include piercing jewelry, IUD ______________________________

Circulatory disorders/cold feet or hands .... ☐ Y ☐ N

Allergic to aloe vera gel or witch hazel .... ☐ Y ☐ N ______________________________

Allergic to shellfish, nuts, bee sting, ANYTHING? .. ☐ Y ☐ N List all, be SPECIFIC______________________________

Do you still have periods?.................................... ☐ Y ☐ N If no, explain______________________________

Are your periods normal?..................................... ☐ Y ☐ N If no, describe______________________________

Hysterectomy... ☐ Y ☐ N Ovaries removed? ______________________________

PCOS? (Polycystic Ovary Syndrome)...................... ☐ Y ☐ N Has a doctor diagnosed you? ☐ Y ☐ N ______________________________

.... Meds taken for it? List:______________________________