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. LATE arrivals: We reserve time to complete your service when you book with us. If you arrive late, your treatment time will be cut short, or will have to be rescheduled so as not to inconvenience guests after you. You will be charged for the entire session time you scheduled. In general, more than 5 minutes late for a 15-minute session or 10 minutes late for a 30-minute or longer session will need to reschedule. You will be responsible for the missed session fee. If I am running late, you will receive your full treatment time.
4. 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: _____