Brilliant Bodywork

Skin Care History Questionnaire and Waiver

Please answer the following questions so that your Skin Care Specialist may have a better understanding of your general health and lifestyle, thereby enabling us to accurately analyze and assess your skin care needs.

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____

Cell Phone: _____ Date of Birth: _____

E-mail address: _____

How did you hear about Brilliant Bodywork? _____

Health History- **Use letter X to answer questions that require selection** (ex. Yes X__No___)

What type of work do you do? _____

Have you seen a dermatologist in the past year? Yes _____ No _____

If yes, list dermatologist's name, contact info and reason for visit _____

_____

Are you currently taking any medications? Yes _____ No _____

If yes, please list _____

_____

What is your genetic background? (I.e. Irish, German) _____

How is your general health? _____ Excellent _____ Good _____ Fair _____ Poor

Please rate your stress level from 1-5 (5 being the highest): _____

Please circle the following conditions you have or had experienced:

☐hypertension	☐ contact lenses	☐ high cholesterol	☐ asthma
☐metal plate	☐ anemia	☐ varicose veins	☐ hepatitis
☐diabetes	☐ lupus	☐seizures	☐ tooth fillings
☐fainting	☐ irregular pulse	☐ eating disorder	☐ high/low blood pressure
☐cold sores	☐ claustrophobia	☐ heart attack	☐autoimmune disorder
☐hernia	☐ cancer	☐ epilepsy	☐ melasma
☐stroke	☐ thyroid disorders	☐ headaches	

Do you take nutritional supplements? Yes _____ No _____

Do you exercise? Yes _____ No _____

Do you have a tendency to scar? Yes _____ No _____

Allergies:

Have you ever had an allergic reaction to any of the following?

ASPIRIN OR SALICYLATES Yes _____ No _____

MILK Yes _____ No _____

APPLES Yes _____ No _____

CITRUS Yes _____ No _____

GRAPES

INGREDIENTS IN SKIN CARE PRODUCTS Yes _____ No _____

FISH, MARINE OR IODINE ALLERGIES Yes _____ No _____

LATEX Yes _____ No _____

INSECT BITES/ STINGS Yes _____ No _____

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

_____

_____

Please list any other known allergies:

_____

Have you ever had Herpes Simplex? Yes _____ No _____

If yes, have you ever been treated with☐ Denavir® ☐ (Penciclovir), ☐ Zovirax® ☐ (Acyclivor) ☐ Abreva?

Yes _____ No _____

Are you being treated for Hepatitis? Yes _____ No _____

Female clients only:

Are you on hormone replacement therapy? Yes _____ No _____

Are you presently taking birth control pills? Yes _____ No _____

Are you pregnant or nursing? Yes _____ No _____

Skin Care History

Are you currently having skin treatments? Yes _____ No _____

If yes, what type of treatment(s) _____

Please check if you are presently using or have used in the past any of the following:

_____ Benzoyl Peroxide (BP)

_____ Glycolic Acid (AHA)

_____ Lactic Acid (AHA)

_____ Resorcinol

_____ Salicylic Acid (BHA)

Do you have or have you had any of the following in the last 14 days?

_____ Facial Cosmetic Surgery

_____ Botox Injections

_____ Collagen Injections

_____ Fillers

_____ Light Treatments

_____ Laser Resurfacing

_____ Microdermabrasion

Other _____

HOME CARE:

What Skin care products are you currently using at home?

Cleanser _____

Toner _____

Moisturizer _____

SPF _____

Vitamin C _____

Exfoliants/Scrubs _____

Specialty Products _____

Mask _____

PRESCRIPTION PRODUCTS:

_____ Tretinoin (Retin A, Retin-A, Micro®, Renova, Avita)

_____ Adepalene (Differin®)

_____ Azelaic Acid (Azelex®, Finacea™)

_____ Tazarotene (Tazorac®)

_____ Isotretinoin (Accutane)

_____ Triluma

_____ Metrogel

Any other topical antibiotics: _____

PLEASE CHECK IF YOU ARE PRESENTLY EXPERIENCING OR HAVE EXPERIENCED ANY OF THE FOLLOWING:

_____ Skin Cancer
_____ Dermatitis
_____ Keloid Scarring
_____ Acne
_____ Rosacea
_____ Broken Capillaries
_____ Treatment Reactions
_____ Hypopigmentation
_____ Hyperpigmentation
_____ Melasma
_____ Sun Spots
_____ Unwanted Hair Growth
_____ Ingrown Hair

SUN PROTECTION:

Do you use a sunscreen? Yes _____ No _____

What level of protection? _____

Do you sunbathe or participate in outdoor activities? Yes _____ No _____

Do you tan in a tanning booth? Yes _____ No _____

Have you tanned in a tanning booth in the last 14 days? Yes _____ No _____

Have you had any direct sun exposure in the last 10 days? Yes _____ No _____

WHEN EXPOSED TO THE SUN DO YOU:

_____ Always burn, never tan
_____ Always burn, sometimes tan
_____ Sometimes burn, sometimes tan
_____ Always tan

Do you feel your skin is sensitive? Yes _____ No _____

WHAT SKIN CONDITIONS DO YOU WANT TO IMPROVE?

_____ Acne and/or breakouts
_____ Facial Scarring
_____ Hyperpigmentation (freckles, age spots)
_____ Hypopigmentation
_____ Enlarged Pores
_____ Fine Lines and Wrinkles
_____ Less Unwanted Hair Growth
_____ Stretch Mark Reduction
_____ Rosacea Reduction
_____ Sun Spots
_____ Skin Tags

OTHER _____

CONTRADICTIONS

- ☐**Yes** ☐ **No** Pacemaker or internal defibrillator.
- ☐ **Yes** ☐ **No** Superficial metal or other implants in the treatment area.
- ☐ **Yes** ☐ **No** Current or history of skin cancer, or current condition of any other type of cancer, or pre-malignant moles.
- ☐ **Yes** ☐ **No** History of any kind of cancer. *
- ☐ **Yes** ☐ **No** Severe concurrent conditions, such as cardiac disorders.
- ☐**Yes** ☐**No** Pregnancy and nursing.
- ☐ **Yes** ☐ **No** Impaired immune system due to immunosuppressive diseases such as AIDS and HIV, or use of immunosuppressive medications. *
- ☐ **Yes** ☐ **No** Diseases which may be stimulated by light at the wavelengths used, such as history of Systematic Lupus Erythematous, Porphyria, and Epilepsy. *
- ☐ **Yes** ☐ **No** Patients with history of diseases stimulated by heat, such as recurrent Herpes Simplex in the treatment area, may be treated only following a prophylactic regimen.
- ☐ **Yes** ☐ **No** Poorly controlled endocrine disorders, such as Diabetes, or PCO for hair removal.
- ☐ **Yes** ☐ **No** Any active condition in the treatment area, such as sores, Psoriasis, eczema, and rash.
- ☐ **Yes** ☐ **No** History of skin disorders, keloids, abnormal wound healing, as well as very dry and fragile skin.
- ☐ **Yes** ☐ **No** History of bleeding coagulopathies, or use of anticoagulants except for low-dose aspirin.
- ☐ **Yes** ☐ **No** Use of medications, herbs, food supplements, and vitamins known to induce photo-sensitivity to light exposure at the wavelengths used, such as Isotretinoin (Accutane) within last 6 months, Tetracycline's, or St. John's Wort within the last two weeks.
- ☐ **Yes** ☐ **No** Facial laser resurfacing and deep chemical peeling within the last three months, if face is treated.
- ☐**Yes** ☐ **No** Any surgical procedure in the treatment area within the last three months or before complete healing.
- ☐ **Yes** ☐ **No** Needle epilation, waxing or tweezing within the last six weeks prior to hair removal treatment.
- ☐ **Yes** ☐ **No** Treating over tattoo or permanent makeup.
- ☐ **Yes** ☐ **No** Excessively tanned skin from sun, sun-beds or tanning creams within the last two weeks.

POSSIBLE SIDE EFFECTS

Although effects are rare and expected to be transient, any adverse reaction should be immediately reported to the physician. Side effects may include any of those conditions listed below. Side effects may appear either at the time of treatment or shortly after. Some dark-skinned patients may have a delayed response one-to-two days after treatment and should be evaluated post-test accordingly.

The side effects may include:

- Discomfort
- Excessive skin redness (erythema) and/or swelling (edema)
- Damage to natural skin texture (crust, blister, burn)
- Change of pigmentation (hyper- or hypo-pigmentation)
- Scarring

I have read and understand all possible side effects that may occur during treatment.

Client Signature: _____ Date: _____

Is there any other necessary information your Skin Care Specialists should know before beginning your treatment?

Yes _____ No _____

If yes, please explain _____

_____

I consent to photographs being taken to evaluate treatment effectiveness

Client Signature: _____ Date: _____

I have acknowledged that all the information provided by me is true and correct to the best of my knowledge. I understand that some skin conditions may require more than one treatment and home care products to achieve the result desired. Results cannot be guaranteed due to individual skin type(s) and condition(s). I understand I need to sign this waiver prior to every treatment provided, with ANY changes pertaining to the above questionnaire.

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____

☐ **Yes** Please check if permission is granted to use pictures for marketing and training purposes. Your name will remain anonymous.