TIMELESS BEAUTY AESTHETICS

Client Information & Health History

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell#: _____ Work#: _____ Home#: _____

Email: _____

Preferred method of contact: email ____ cell# ____ work# ____ home# ____

Date of Birth: _____ Occupation: _____

How did you hear about us? _____

Do you have any medical conditions? _____

_____

Please list any current medications, vitamins, or supplements:

Name	Dosage	Frequency

Do you take Motrin, Advil, daily Aspirin, or other anticoagulants? _____

Please list any allergies to latex, medications, food, or other substance? _____

_____

Please list all current/past surgeries or surgical procedures: _____

_____

Do you smoke? _____ Are you pregnant? _____

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Please answer ALL of the following questions:

	Yes	No	If yes, please explain
Pacemaker			
Cancer			
Tumor			
Epilepsy			
Heart Condition			
High Blood Pressure			
Diabetes			
Inflammation/Infection			
Autoimmune Disorder			
Multiple Sclerosis			
Muscular condition			
Varicose veins			
Allergy—Rubber/Metals			
Lack of normal skin sensation			
Skin disease			
Thrombosis/Phlebitis			
Metal Implants/Screws			
Prosthesis/Silicone			
Cold sores, fever blisters, Herpes I or II			

Any other medical conditions that are not listed? _____

_____

Do you have a history of keloid scarring? _____

What is your ethnicity? [i.e., German, Irish, etc. to determine skin type and treatment)

_____

Natural hair color: _____ Natural eye color: _____

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Name: _____ Date: _____

What skincare products do you use? _____

_____

When did you use these last? _____

Do you use: Rentin-A? ____ Glycolic Acid? ____ Anticoagulants, Aspirin, Motrin, Advil? ____

Have you used Accutane within the past year? _____

Do you have any permanent make-up or tattoos? _____

_____

Have you ever had any skin treatments such as Lasers, microdermabrasion, chemical peels, or injections?

Treatment	Date

General appearance or skin concerns [please check all that apply):

	Fine lines and wrinkles		Facial redness
	Facial folds—around mouth and/or nose		Dark circle under eyes
	Rough texture of skin		Thin lips
	Tired looking skin		Facial acne
	Dry skin		Body acne
	Oily skin		Facial or leg veins
	Sagging skin		Thinning lashes
	Uneven skin tone		Neck laxity
	Brown spots/hyperpigmentation/melasma		Large pores

Please rank your top five concerns:

1._____
2. _____
3. _____
4. _____
5. _____

Comments:

_____
_____
_____
_____
_____

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Products or treatments of interest to you [please check all that apply):

	Skin care advice		Depigmentation
	Skin care products		Botox® Cosmetic
	Removing spider veins		Dermal Fillers
	Eye treatments		Lightening cream
	Peels		Latisse®

When I look at my face in the mirror, I believe I look younger than, the same, or older than my true age? _____

When I look in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles and/or skin laxity? _____

Consent to Photograph:
The undersigned hereby authorized Timeless Beauty Aesthetics to photograph and agrees that the negatives, print, or digital images prepared there from may be used for the purposes checked below:

- Medical Record
- Education and/or Demonstration
- Publication
- Other specified

_____

I have read and understand this agreement:

Client Signature: _____ **Date:** _____

Cancellations:
Your scheduled appointment is reserved exclusively for you. Should you need to cancel or reschedule your appointment, please notify us at least 24 hours ahead. We do require a credit card be kept on file for spa appointments, and your card will be charged a fee of $50 for any late cancellations or no-shows.

Client Signature: _____ **Date:** _____

TIMELESS BEAUTY AESTHETICS

Client Rights & Responsibilities

We are committed to serving you with compassion, care, and respect. As one of our valued clients, you are entitled to the following:

YOU HAVE THE RIGHT:

- To be treated with dignity and respect
- To know the names and professional status of the person[s] serving you
- To privacy and confidentiality
- To receive accurate information about your health-related concerns
- To know the effectiveness and possible side effects of all forms of treatment
- To participate in choosing the form of treatment best suited to your skin
- To receive education and counseling about treatments
- To review your medical record with your clinician
- To amend your medical record
- To receive any information about potential services or related costs

YOU HAVE THE RESPONSIBILTY:

- To seek medical attention promptly
- To be honest about your medical history, as well as, your sun exposure
- To ask questions about anything you do not understand
- To follow health advice and instructions
- To report any significant changes in your health or medications
- To respect the clinical policies, and provide useful feedback regarding our service and policies
- To attend scheduled appointments, or cancel at least 24 hours in advance

I authorize, Timeless Beauty Aesthetics, to perform the treatments or procedures recommended. I acknowledge that no guarantee, either expressed or implied, have been made to me regarding the outcome of any treatments or procedures.

I fully understand that it is impossible to make a guarantee regarding the outcome of any medical treatments or procedures.

I understand I am financially responsible for all amounts due at the time services are rendered, and for any appointment I fail to attend without at least 24 hours notice.

I also authorize the release of information to a licensed physician of the facility's choosing for the purposes of professional interpretation and establishment of his/her recommendations.

Client Signature _____ **Date** _____

Reviewed By_____ **Date** _____