*Progressive Laser LLC*

*"Science enhancing Beauty..."*

**Skin Consultation & Informed Consent**

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_Zip Code \_\_\_\_\_\_\_\_

Home/Mobile Phone (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you were referred to us by someone please name the individual so we may thank them: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Skin Concerns**

**What are your skin concerns?**

* Age Spots
* Dark Spots
* Lines/Wrinkles
* Pimples/Pustules
* Blackheads
* Dehydrated Skin
* Oily Skin
* Scarring
* Broken Capillaries
* Dry/Flaking Skin
* Permanent Redness
* Sensitive Skin
* Cysts
* Flushing
* Pigmentation
* Whiteheads

**Does your** **skin breakout?**

* Almost Always
* Frequently
* Rarely
* Never

**Have you ever been diagnosed with acne rosacea?**  Yes\_\_\_ No\_\_\_

**Have you ever been diagnosed with rosacea?** Yes\_\_\_ No\_\_\_

**Lifestyle**

**Please Check YES or NO to the following questions:**

Do you smoke? Yes\_\_\_ No\_\_\_

Do you go to tanning booths? Yes\_\_\_ No\_\_\_

Do you spend much time in the sun? Yes\_\_\_ No\_\_\_

Do you pick at your skin? Yes\_\_\_ No\_\_\_

Are you usually stressed? Yes\_\_\_ No\_\_\_

Do you exercise? Yes\_\_\_ No\_\_\_

Do you use fabric softener? Yes\_\_\_ No\_\_\_

Are you trying to get pregnant? Yes\_\_\_ No\_\_\_

Are you pregnant? Yes\_\_\_ No\_\_\_

**Do you suffer from any of the following?**

* Bloating
* Constipation
* Diarrhea
* Gas
* Indigestion

**Do you regularly eat any of the following?**

* Dairy Products
* Milk/Cheese
* Sushi
* Fast Food
* Pasta
* Kelp
* White Bread
* Seaweed

**Have you received any of the following?**

**Corrective Peels? Yes\_\_\_ No\_\_\_**

\*\*If yes, please answer:

Time since last treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you been receiving tx? \_\_\_\_

How frequently do you receive tx? \_\_\_\_\_\_\_

**Laser Hair Removal? Yes\_\_\_ No\_\_\_**

\*\*If yes, please answer:

Time since last treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you been receiving tx? How frequently do you receive tx? \_\_\_\_\_\_\_

**Microdermabrasion? Yes\_\_\_ No\_\_\_**

\*\*If yes, please answer:

Time since last treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you been receiving tx? \_\_\_\_

How frequently do you receive tx? \_\_\_\_\_\_\_

**Fillers or injectables? Yes\_\_\_ No\_\_\_**

\*\*If yes, please answer:

Time since last treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you been receiving tx? \_\_\_\_

How frequently do you receive tx? \_\_\_\_\_\_\_

**Glycolic Peels? Yes\_\_\_ No\_\_\_**

\*\*If yes, please answer:

Time since last treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you been receiving tx? \_\_\_\_

How frequently do you receive tx? \_\_\_\_\_\_\_

**Plastic Surgery? Yes\_\_\_ No\_\_\_**

\*\*If yes, please answer:

Time since last treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you been receiving tx? \_\_\_\_

How frequently do you receive tx? \_\_\_\_\_\_\_

**Skin Cancer Removal? Yes\_\_\_ No\_\_\_**

\*\*If yes, please answer:

Time since last treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you been receiving tx? \_\_\_\_

How frequently do you receive tx? \_\_\_\_\_\_\_

**Laser Resurfacing? Yes\_\_\_ No\_\_\_**

\*\*If yes, please answer:

Time since last treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you been receiving tx? \_\_\_\_

How frequently do you receive tx? \_\_\_\_\_\_\_

**Are you under a dermatologists care? Yes\_\_\_ No\_\_\_**

If yes, which dermatologist and why: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Please list any supplements you take:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Medical**

**Allergies**

* Latex Allergy **Yes\_\_\_ No\_\_\_**
* Sulphur Allergy **Yes\_\_\_ No\_\_\_**
* Glycolic **Yes\_\_\_ No\_\_\_**
* Salicylic **Yes\_\_\_ No\_\_\_**
* Shellfish **Yes\_\_\_ No\_\_\_**
* Aspirin **Yes\_\_\_ No\_\_\_**
* Skin Care Allergies **Yes\_\_\_ No\_\_\_**

**Do you suffer from the following?**

* Asthma **Yes\_\_\_ No\_\_\_**
* Cancer **Yes\_\_\_ No\_\_\_**
* Contagious disease **Yes\_\_\_ No\_\_\_**
* Depression **Yes\_\_\_ No\_\_\_**
* Auto Immune **Yes\_\_\_ No\_\_\_**
* Diabetes **Yes\_\_\_ No\_\_\_**
* Eczema/Psoriasis **Yes\_\_\_ No\_\_\_**
* Endometriosis **Yes\_\_\_ No\_\_\_**
* Phlebitis/Thrombosis **Yes\_\_\_ No\_\_\_**
* Melanoma **Yes\_\_\_ No\_\_\_**
* Epilepsy **Yes\_\_\_ No\_\_\_**
* Gut Disorder **Yes\_\_\_ No\_\_\_**
* Heart Condition **Yes\_\_\_ No\_\_\_**
* High Blood Pressure **Yes\_\_\_ No\_\_\_**
* Low Blood Pressure **Yes\_\_\_ No\_\_\_**
* Meatal Prosthesis **Yes\_\_\_ No\_\_\_**
* Metal Implant **Yes\_\_\_ No\_\_\_**
* Polycystic Ovaries **Yes\_\_\_ No\_\_\_**

**Have you taken any of the following in the last 6 months?**

* Antibiotics for acne **Yes\_\_\_ No\_\_\_**
* Antidepressants **Yes\_\_\_ No\_\_\_**
* Antihistamines **Yes\_\_\_ No\_\_\_**
* Birth control Pill **Yes\_\_\_ No\_\_\_**
* Cyclosporin **Yes\_\_\_ No\_\_\_**
* Danazol **Yes\_\_\_ No\_\_\_**
* Differin **Yes\_\_\_ No\_\_\_**
* Dilantin **Yes\_\_\_ No\_\_\_**
* Disulfram **Yes\_\_\_ No\_\_\_**
* Gonadptropin **Yes\_\_\_ No\_\_\_**
* HR Therapy **Yes\_\_\_ No\_\_\_**
* Imuran **Yes\_\_\_ No\_\_\_**
* Isonaziad **Yes\_\_\_ No\_\_\_**
* Izonazaid **Yes\_\_\_ No\_\_\_**
* Lithium **Yes\_\_\_ No\_\_\_**
* Recreational Drugs **Yes\_\_\_ No\_\_\_**
* Retin A **Yes\_\_\_ No\_\_\_**
* Roaccutane **Yes\_\_\_ No\_\_\_**
* Steroids **Yes\_\_\_ No\_\_\_**
* Testosterone **Yes\_\_\_ No\_\_\_**
* Thyroid Medication **Yes\_\_\_ No\_\_\_**
* IVF supplementation **Yes\_\_\_ No\_\_\_**

**If yes to any of the above, please state which medication & for how long: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.**

**If you have ever been on Roaccutane, how long for and how long since last use:\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.**

**If you have ever had IVF, how long ago and how long for**:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.**

**Current Routine**

**Please list any of the products you are currently using:**

Cleanser \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **AM\_\_\_ PM\_\_\_**

Toner \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **AM\_\_\_ PM\_\_\_**

Serums \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **AM\_\_\_ PM\_\_\_**

Moisturizer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **AM\_\_\_ PM\_\_\_**

Eye care \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **AM\_\_\_ PM\_\_\_**

SPF \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **AM\_\_\_ PM\_\_\_**

Exfoliant \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Weekly: \_\_\_\_\_**

Mask \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Weekly: \_\_\_\_\_**

Body Products \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Foundation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Concealer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Setting Powder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Blush/Bronzer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Setting Spray \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Shampoo \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Conditioner\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hair Treatments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Leave in hair products \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you currently go to a hair dresser, how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I give consent to have the following treatment(s) performed:**

|  |
| --- |
| ☐Yes ☐No **HydraFacial**  ☐Yes ☐No **Dermaplaning**  ☐Yes ☐No **Eminence Organics Facial**  ☐Yes ☐No **Roccoco Botanicals Facial**  ☐Yes ☐No **Nano-Needling**  ☐Yes ☐No **Celluma LED Therapy**  ☐Yes ☐No **Microcurrent**  ☐Yes ☐No **Ultrasound**  ☐Yes ☐No **Galvanic Current**  ☐Yes ☐No **Lymphatic Drainage** |
| **I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, aesthetician, therapist, doctor or nurse of my current medical or health conditions and to update this history. A currant medical history is essential for the caregiver to execute appropriate treatment procedures.** |

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Estheticians Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_