New Client History

First Name: _____ Date: _____

Last Name: _____ Birth Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____ Occupation:_____

Ethnic Background (i.e. Spainsh, Italian, African American, German, Irish): _____

How did you hear about us? _____

What brings you in today? _____

What are your body/skin care goals? _____

Medical History

Do you have any chronic medical conditions of which we should be aware? Yes No

If yes, please list: _____

Do you have any allergies to any medications, latex, herbal or natural supplements? Yes No

If yes, please list: _____

Are you currently taking prescription, herbal, or over the counter medication? Yes No

If yes, please list: _____

Do you have, or have you had any changes in medical history recently? _____

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

_____

Do you have any metal in your body, including active implants such as a pacemaker, cardiac defibrillator, cochlear implant, or non-active implants such as screws, stents, hip replacement, knee replacement? Yes No

If yes, please list: _____

Have you experienced significant weight change in the past 12 months? Yes No

Have you taken Accutane within the past year? Yes No

Are you on any anticoagulants, daily Aspirin, Motrin, or Advil? Yes No

Are you a smoker? Yes No

Do you have veneers on your teeth? Yes No

Do you have a history of cold sores, fever blisters or herpes 1 or 2? Yes No

If yes, when was your last outbreak? _____

Do you have a history of Keloid scarring? Yes No

Do you have a history of any skin disease or sensitivity? Yes No

If yes, please explain. _____

Do you have a history of hypo/hyper-pigmentation? Yes No

Women Only

Are you or could you be pregnant? Yes No

Are you currently breastfeeding? Yes No

Are your menstrual cycles normal? Yes No

Skin/Injectables

Please tell us about your skin by circling all that apply:

Dry Oily Normal Acne Large Pores Melasma

Hyper-Pigmentation Hypo-Pigmentation Broken Capillaries

Do you have or have you ever had any of the following? Please circle all that apply.

Botox Dermal Fillers Facial Implants

Poor Healing Blood Clots Liver/Kidney Failure Cancer

Pacemaker Internal Defibrillator Artificial Joint

What is your natural; Hair color? _____ Eye color? _____

Have you had any recent sun exposure in the past 4-6 weeks including but not limiting to, tanning beds, tanning creams or spray-on tans? Yes No

If yes, please explain. _____

Please add any additional information you would like to include. _____

_____

_____ _____

Client Signature Date

_____ _____

Witness Date

_____ _____

Physician Signature Date

Clients Rights and Responsibilities

You have the right to:

To be treated with respect and dignity.

To know the name(s) 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 potential 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.

To receive any information about potential service or related service.

You have the responsibility to:

To be honest about your medical history.

To seek medical attention promptly if needed, and to provide useful feedback.

To be honest about your sun exposure.

To ask questions about anything you do not understand.

To follow health advice and instructions.

To report any significant change in your health.

To respect client policies.

To show up to appointments or cancel 48 hours in advance.

I acknowledge I have read, agree and received a copy of my rights and responsibilities.

Client Signature _____ Date _____

Authorizations/Policies

Treatment Authorization

I authorize InVogue Rejuvenation & Body Sculpting Center to perform the treatment(s) or procedure(s) recommended. I acknowledge there is no guarantee; either expressed or implied has been made to me regarding the outcome of any treatment or process.

Initials _____

Photograph Authorization

I authorize/consent InVogue Rejuvenation & Body Sculpting Center to photograph all areas to be treated pre/post procedure(s). I understand all picture(s) will remain confidential and solely used for the purpose of evaluating results.

Initials _____

Cancellation Policy

We request/require that you give us ample notice if you need to cancel or reschedule your appointment. Ideally 48 hours prior.

We do require a credit card to be kept on file for any/all appointments. If you no show to your appointment, your card will be charged a non-refundable $50.00 fee.

Initials _____

Payment Policy

I understand that all financial responsibility for all procedure(s) is due when services are rendered, as for any outstanding balance for cancelled appointments not cancelled prior to 48 hours of my scheduled appointment.

Initials _____

I agree and understand all the above policies and authorizations.

_____

Client printed name

_____ _____

Client Signature Date