Alite Laser Hair Removal & Skin Rejuvenation

504 W.17th Street, Austin, TX 78701

CLIENT REGISTRATION AND HEALTH ASSESSMENT FORM

Date______________ Name _____________________________________MI:________Date of Birth ___________

Address _____________________________________City ________________________State ____ Zip _________

Home Tel. (   ) ____________________________ Mobile Tel. (   ) _______________________________

Email Address ____ Occupation _____________________________

How did you hear about us? ____

Person to contact in case of emergency: ________________ Relationship _____________ Tel. _________________

MEDICAL BACKGROUND:

Do you have ANY chronic medical history we should know about? ☐ Yes ☐ No

Please list: ____

Are you under a doctor's care now? Explain: ____

____

Have you ever been treated with hormone medication? ____

List present medications, including topical ____

____

List any surgery in past 6 months ____

Skin sensitivity to soaps, lotions, hydroquinone or skin bleaching agents? __________________________________

Allergy to lidocaine or any numbing agents? ____

Does your skin get blotchy, red or irritated easily? ____

Are you TAN in area/s to be treated (from sun, spray on, and/or tanning salon)? ____________________________

Past chemical peel? If yes, when? ____________ Tattoo or permanent makeup in area/s to be treated? ____________

Currently pregnant or trying to conceive? ______________________ List any implants ________________________

We do not recommend laser therapy if any of the following conditions exist. Please check any box which describes your current health condition.

- ☐ Pregnancy
- ☐ Photosensitivity disorders
- ☐ Herpes (active)
- ☐ Shingles (active)
- ☐ Seizure disorders triggered by light
- ☐ Bacterial infections

Have you ever experienced, been treated for or used any of the following? (please circle)

Acne   Allergies   Herpes   Cold Sores   Hemophiliac   Polycystic Ovaries   Diabetes   HIV   Latex Allergy

Hepatitis A,B,C   Heart Problems   Anti-Coagulant   High Blood Pressure   Thyroid   Hysterectomy   Menopause

Birth Control Pill   Irregular Periods   Pregnancy   Retin-A or Alpha Hydroxy   Cancer   Psoriasis   Shingles

Skin Pigmentation   Keloid   Accutane   Photosensitizing medication   Multiple Sclerosis

ALS (Amyotrophic Lateral Sclerosis)

Please explain any circled items: ____

____

SKIN TYPE: To determine your skin type, please check the one box which best describes your reaction to sun exposure:

_____ Skin Type I   Never tans, always burns (extremely fair skin, blonde/red hair)
_____ Skin Type II   Occasionally tans, usually burns (fair skin, sandy to brown hair, green/brown eyes)
_____ Skin Type III   Often tans, sometimes burn during first exposure to sun (medium skin, brown hair)
_____ Skin Type IV   Always tans, never burns (Olive skin, brown/black hair)
_____ Skin Type V   Never burns (dark brown skin, black hair)
_____ Skin Type VI   Never burns (black skin, black hair)

HAIR REMOVAL: Please list **present area/s** you are interested in treating.
(i.e. facial, back, chest, neck, bikini (regular or Brazilian), underarms, leg tops, leg bottoms, arms, hands, feet, etc.)
AND please list desired method/s of hair removal **(i.e. laser, waxing, electrolysis):**

____

Please list future, possible areas and methods (laser, wax, electrolysis):

____

Previous Hair Removal – Please list area/s, method/s used to remove and approximate date last removed:

____

SKIN REJUVENATION – Laser and Photo Facials

(Treat brown spots, wrinkles, melasma, etc.) Please check areas interested in:

Face _____   Arms_____   Legs _____   Chest _____   Back _____   Stomach _____   Other_____________

Please explain: ____

I acknowledge that I am not allergic to lidocaine or any topical numbing agents, to the best of my knowledge.   ______________________________
Client Signature

I acknowledge that the information provided on this form is accurate and complete:

______________________________   ______________________________
Client Signature   **Date**