Cary Massage

Hair Removal Assessment Form

Date:_____

Name:_____ Birthday:___/____/____

Address:_____City:_____State:____Zip:_____

Home Phone:_____ Work:_____Cell:_____

Email:_____

1. Have you been seen by a dermatologist? Yes___No___ If yes, for what reason?
_____.
2. Please list all medications that you take regularly. Include hormones, vitamins, etc.
_____.
3. Are you taking Accutane or any other acne medications? Yes___No____ If yes, for how long?
_____.
4. Do you use Retin-A, Renova, other topical Vitamin A, or hydroquinone? Yes____No____
If yes, how long?_____.
5. Do you have any allergies? Are you allergic to any medications? Yes____No____
If yes, please list allergies._____.
6. Are you pregnant or lactating? Yes____No____
7. Have you had any of the following procedures?

Laser resurfacing. Yes____ Date_____No_____
Light chemical peel. Yes____Date_____No_____
Medium/heavy chemical peel. Yes_____Date_____No_____

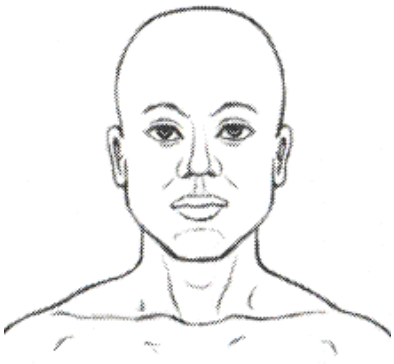
8. Do you ever experience tightness or flaking of your skin? Yes____No_____
9. Do you tan or frequently use tanning booths? Yes_____No_____
10. Do you have a history of fever blisters or cold sores? Yes____No_____

Release Form for Hair Removal

I,_____, am _____am not____presently using:
____Retin-A or any other topical vitamin A
____Accutane or any other acne medication
____any exfoliant or hydroxy-based products
____any medications such as cortisone, blood thinners, or diabetic medication
____I understand that if I begin using any of the above products and do not inform the esthetician prior to hair removal, I am accepting full responsibility for any skin reactions.
____The hair removal process has been thoroughly explained to me, and I have had an opportunity to ask questions and receive satisfactory answers.

Client Signature:_____Date:_____

Technician Signature:_____Date:_____



Type of Treatment	Signature	Date