CLIENT CONSULTATION AND RELEASE FORM

Please read carefully, complete, sign and date this form prior to your treatment.

Name: _____ Phone: (_____) _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

☐ HYDRAFACIAL™ ☐ BLUE LED LIGHT THERAPY ☐ RED LED LIGHT THERAPY

☐ LYMPHATIC/MASSAGE THERAPY ☐ WET DIAMOND (Medical Use Only)

☐ MICRODERMABRASION

SECTION 1: MEDICAL INFORMATION

- Do any of the following conditions relate to you?

Do you have any of the following allergies?

Shellfish
Aspirin
Sulfur
Preservatives

Other (Please list):
_____
_____
_____

YES	NO	Contraindications
☐	☐	Accutane or other similar medication
☐	☐	Autoimmune disease, HIV, lupus, hepatitis
☐	☐	Blood thinners – Heparin, Coumadin, Warfarin, etc.
☐	☐	Breast feeding, pregnancy
☐	☐	Cancer or post-cancer treatments
☐	☐	Cardiovascular problems
☐	☐	Cold sores or fever blisters without pre-medication
☐	☐	Cortisone or steroid injections
☐	☐	Cosmetic injections, fillers or implants, (i.e. Botox®, collagen)
☐	☐	Eczema, psoriasis
☐	☐	Enlarged or painful glands
☐	☐	Epilepsy
☐	☐	Facial waxing services w/in 7-14 days
☐	☐	Heart ailment
☐	☐	Hypertension/high blood pressure
☐	☐	Inflammatory conditions
☐	☐	Irregular, pigmented moles, warts or growths, unidentified facial growth or mark
☐	☐	Keloids, pigmented scars, icepick scars, new scar tissue
☐	☐	Laser procedures, chemical peels, dermabrasion, microdermabrasion
☐	☐	Light sensitive medication

YES	NO	Contradictions
☐	☐	Loose, thin, aged skin
☐	☐	Lymphatic disorder, inflammation of lymph vessels, lymphedema
☐	☐	Medication, list here:
☐	☐	Pacemaker or metal implants
☐	☐	Phlebitis, varicose veins
☐	☐	Recent accident or serious injury
☐	☐	Recent surgical or dental procedure
☐	☐	Rosacea, telangiectasia/couperose
☐	☐	Retin-A, Retinol
☐	☐	Skin abrasions or lesions
☐	☐	Stage III or IV acne
☐	☐	Skin-lightening or bleaching agent
☐	☐	Sunburn
☐	☐	Swollen or infected tonsils
☐	☐	Thyroid conditions
☐	☐	Type I diabetic
☐	☐	Under medical care for an existing or suspected condition or disease
☐	☐	Viral infection, influenza
☐	☐	Other contraindication at discretion of skincare technician or medical practitioner:

- If you answered **YES** to any of the above questions please explain:

_____
_____

- My interest in skincare treatment is primarily for (i.e. skin rejuvenation, acne, hyperpigmentation, scarring, etc.)

_____
_____

- Specify your areas of concern (i.e. eyes, forehead, etc.)

_____
_____

SECTION 2: CLIENT CONSENT FORM

(Initial each acknowledgement line below)

1. I acknowledge that I have not used Accutane or any medication for the same purpose during the last 12 months. _____*(initial here)*
2. I acknowledge that if I have ever had a cold sore or fever blisters, I should consult with my physician or pharmacist for a pre-use medication to help avoid a possible breakout. That medication should be used each day for two days before, same day, and two days after any aggressive facial exfoliation treatment. _____*(initial here)*
3. I acknowledge that there is no guarantee that dark discoloration of skin will be reduced or fade. Pigmentation may improve or darken with successive treatments. I acknowledge the need for proper skin care home regimen. _____*(initial here)*

4. I acknowledge that my skin might experience temporary irritation, tightness, redness or slight swelling which usually dissipates within 72 hours depending on skin sensitivity. _____*(initial here)*
5. I have disclosed my history of allergies above. _____*(initial here)*
6. I acknowledge that if I am allergic to one or more of the ingredients in the products used, I may experience allergic reactions. _____*(initial here)*
7. I acknowledge that if I fail to use a minimal sunscreen (SPF 30) and follow the direction for use, I am more susceptible to sunburn, sun damage & hyperpigmentation. I should avoid excessive sun exposure, especially between 10am - 2pm. _____*(initial here)*
8. I acknowledge that this treatment is strictly an elective cosmetic procedure and that no medical claims have been expressed or implied. _____*(initial here)*
9. I acknowledge that I should avoid use of aggressive exfoliation, waxing, and products containing acids that are not part of the recommended take-home regimen for 2-4 weeks following the treatment. _____*(initial here)*
10. I acknowledge that I should avoid use of Retin-A type products for a period of time recommended by my physician and/or skincare practitioner during and following the treatment. _____*(initial here)*
11. I acknowledge that I am not pregnant/lactating. _____*(initial here)*
12. I hereby agree to have the treatment performed and agree to follow all pre and post treatment instructions. _____*(initial here)*
13. I acknowledge that I have answered all questions truthfully and completely. _____*(initial here)*
14. I release Edge Systems, the _____ (Aesthetician/Doctor), management and staff of _____ (Clinic/Office) from any and all liability associated with any injuries and/or current or future conditions resulting from the skincare procedures or products. _____*(initial here)*
15. I consent to the use of my before, during and after facial procedure photographs for education, promotion or advertising purposes. My name will not be used to identify these photographs without my written approval. _____*(initial here)*

By signing below, I certify that I have read and fully understood the contents of this consent form, and that the information I provided above are complete, accurate, and up-to-date to my knowledge.

Client Signature: _____ Date: _____

Operator Signature: _____ Date: _____