LASER HAIR REMOVAL

PERSONAL DETAILS

Date

Name

Date of Birth:

Address:

Town/City

Postcode

Occupation

Work/Home Tel:

Mobile Tel:

Email:

General Practitioner's (GP) Details:

Name:

Address:

Contact Number:

How did you hear about us?

Have you read our pre-treatment information pack that we have sent via email?

YES NO

For further discounts, do you want to join our loyalty scheme?

YES NO

If so, how would you like to be contacted?

TEXT EMAIL BOTH

PLEASE NOTE: We do not pass your confidential information onto any third parties.

MEDICAL HISTORY

Are you currently receiving medical treatment? YES NO
Details:

MEDICAL CONDITIONS	Please TICK any of the following that applies to you

Photo-Sensitive Epilepsy		Thrombosis/Phlebitis (blood clots)	
Photo-Sensitive Migraines		Low Blood Pressure	
Cancer or History of Cancer		Are you prone to fainting spells	
Auto Immune Disease		Hyper-Sensitive Skin	
HIV+Blood		Vitiligo	
Any type of Hepatitis		Chloasma/Melasma	
Heart/Cardiac Disorders		Varying Skin Pigmentation	
Pacemaker/Internal Metal Pins		Skin Infections	
Thyroide Therapy		Skin Conditions e.g.psoriasis, eczema	
Kidney Disease		Skin Allergies:	
Asthma		E.g. to rubber gloves	
Depression/Anxiety		to Aloe Vera	
Lupus		to Tea Tree	
Diabetes		Others	
Shingles (within the last 6 months)		Moles on Treatment Area	
Keloid Scarring		Herpes Simplex/Cold Sores	
Recent Surgery		Deep Fillings/Crowns	
Poor Wound Healing		Others	

MEDICINES & SUPPLEMENTS

Roaccutane
Antibiotics
Have you recently taken Antibiotics? **YES** **NO**
St John's Wort
Iron Supplements
Gold Injecctions
Cancer Treatment/Medication

Steroids
Have you recently taken Steroids? **YES** **NO**
Hormone Therapy
Mood Stabilizers
Anti-Depressants
Other

LIFESTYLE

Smoker
Alcohol Consumption
(within the last 24 hours)

Recent Sun/ UV Exposure
Botox/Fillers
(within the last 2 weeks)

WOMEN ONLY N/A

Pregnant
Breastfeeding
Hormone Replacement Therapy
Contraceptive Pill
Irregular Menstrual Cycle

Polycystic Ovarian Syndrome
Endometriosis
Hormone Imbalance
Hirsuitism
Hypertrichosis

HAIR GROWTH HISTORY

What area/s do you wish to have Laser Hair Removal treatment? FACE BODY

Details: ____________________

Have you unsuccessfully tried other methods of hair removal for the unwanted hair growth?

YES NO

Please indicate which methods you have tried:

Shaving Electrolysis Threading Tweezing Waxing Sugaring

Hair Removal Creams Alkaline Wash Prescription Medication

Other ____________________

Have you had any IPL/Laser Hair Removal in the past? YES NO

When did you last remove hair from the areas and what method did you use?

Please estimate how long the unwanted hair growth been present?

Are you aware of any possible cause? YES NO

What are your expectations from your laser treatment?

SKIN TYPE & UV EXPOSTURE

Have you sunbathed or used a sunbed during the past 30 days? YES NO

(Please specify when) ____________________

Are you planning a sun holiday or planning to use sunbeds during the next year? YES NO

(Please specify when) ____________________

How does your skin respond to sun exposure?

Always burns, never tans **Always burns, sometimes tans**

Sometimes burns, always tans **Never burns, always tans**

Therapist's Assessment	**Fitzpatrick Skin Type**	**1**	**2**	**3**	**4**	**5**

PATCH TEST

DATE	THERAPIST	CLIENT'S SIGNATURE ATTAINED? (On all parts of form)	PHOTO TAKEN?	PAYMENT MADE
		YES NO	YES NO	

TREATMENT AREAS	TREATMENT TYPE & WAVELENGTH	SPOT SIZE/TIP	FLUENCE	PULSE DURATION	SHOTS
1.					
2.					
3.					

Post Treatment Reactions (oedema, erythema, etc.)	Aloe Vera Applied	Mineral Make-up applied? Colour etc.
	YES NO	

Notes:

PATCH TEST WAIVER

I confirm that I was given the opportunity to have a Laser/IPL patch test prior to treatment at a later stage. However, I would like to waive this right and take the opportunity to proceed with treatment today.

Client's Signature		Date	

I have assessed the above named client and I can confirm that he/she has not presented with any major contra indication to treatment and I have therefore agreed to perform the full treatment without an initial patch test.

Therapist's Signature		Date	

PATCH TEST OUTCOME

DATE	THERAPIST	WHERE ANY ADVERSE REACTIONS REPORTED?	ADVERSE REACTIONS REPORTED
		YES NO	

AFTER EFECT REPORTED	LENGTH OF TIME IT PERSISTED	IS THE CLIENT HAPPY TO PROCEED WITH TREATMENT?
		YES NO

CLIENT CONSENT (LHR)

The purpose of the agreed treatment is to attempt to reduce or eliminate unwanted, excess hair. The aim of the treatment is to denature the excess hair growth by raising the temperature of the hair follicle enough to damage the follicle's germinative cells without damaging the epidermis and surrounding tissue. Changes in medical circumstances or any introduction of certain drugs or medication (including topical creams and vitamins) may affect the overall results of these treatments.

Treatment is successful on the vast majority of patients, however, individual results cannot be guaranteed. Hair loss is variable and it is extremely difficult to advise on the exact number of treatments required. Many factors can contribute to the growth of excess hair including Heredity, Normal Physiological Changes, Malfunction of the Endocrine System, Medication, Topical Influences and Stress.

I have had a consultation where I have been advised of the benefits and potential side effects of laser treatment for the specific purpose of laser hair reduction. I have read the "Client Consent" information in its entirety and understand and accept all information specified.

The information I have given is correct to the best of my knowledge, and I have not knowingly withheld any details relating to my medical circumstances.

I have been given pre & post treatment guidance notes and agree to strictly adhere to the following advice:

- I agree to inform my Laser Specialist of any changes in my medical circumstances and/or medications during the course of treatment.
- To avoid unprotected UV exposure (including sun exposure and sunbeds) on the treatment areas for a minimum of one month before and after treatment.
- To avoid plucking, waxing and electrolysis. The hair on the treatment area may be shaven or trimmed prior to treatment.
- To apply sunscreen with a high protection factor (SPF30) on the area to be treated if exposed to the sun for 1 month following treatment.
- To avoid all heat treatments for 24-48 hours following laser treatment.
- To avoid aggravating the skin by exfoliating, rubbing or scratching the skin during the following few days after laser treatment.

I understand that I should inform my Laser Specialist of any changes in my medical circumstances immediately. Failure to comply with pre & post treatment advice may result in burning, blistering, scarring, pigmentation and textural changes of the skin.

I have opted to have a patch test performed, and if satisfied, consent to undergo treatment.

Client's Signature		**Date**	
Therapist's Signature		**Date**	

CLIENT MEDICAL DECLARATION

I hereby agree to inform the Laser Specialist about any changes in my medical circumstances including medical investigation, medical diagnosis, medication, or any recent illnesses.

I also agree with the following statements:

- I am not pregnant,
- I have not had UV exposure (including sun exposure and sunbeds) for a minimum of 4 weeks prior to treatment.
- I have not applied any false tanning products to the area to be treated for a minimum of 1 week prior to the procedure,
- I am not undergoing any medical investigative tests,
- I am not undergoing any chemotherapy, radiotherapy or takin any preventative medication for cancer,
- I have not taken Accutane for 12 months,
- I have not had any recent surgery,
- I do not have any broken skin or skin infections on the area to be treated,
- I am not under the influence of alcohol or illegal substances,
- I agree to follow all post treatment guidelines & advice.

I agree with all details outlined within the "Medical Declaration" and I understand that any changes in my medical circumstances will be recorded.

Date	Client's Signature	Reported Changes to Medical Circumstances