Patient Profile

Name: Last: _____ First: _____ DOB: _____ Age: ____ Sex: _____

Address: _____

City/State/Zip Code: _____

Home Phone: _____ Cell: _____

Email: _____

About You

What is your hereditary background?

- ☐ Black/African American
- ☐ Caribbean
- ☐ Scandinavian/Nordic
- ☐ Irish
- ☐ English
- ☐ Asian
- ☐ Mediterranean
- ☐ Hispanic
- ☐ Latin
- ☐ Native American
- ☐ Middle Eastern
- ☐ Other _____

Natural eye color: _____

Natural hair color: _____

Do you consider your skin: (circle the best option) Sensitive / Resilient / Unsure

Describe your skin: (Check all that applies)

- ☐ Normal
- ☐ Dry
- ☐ T-zone/ Combination
- ☐ Thick
- ☐ Thin
- ☐ Saggy
- ☐ Firm
- ☐ Oily
- ☐ Acne
- ☐ Comedones/ Blackheads
- ☐ Milia
- ☐ Cysts
- ☐ Breakouts
- ☐ Acne-scarred
- ☐ Large pores
- ☐ Small pores
- ☐ Rosacea
- ☐ Eczema
- ☐ Freckled
- ☐ Sun-damaged
- ☐ Melisma
- ☐ Hyperpigmentation
- ☐ Hypopigmentation
- ☐ Uneven/Blotchy
- ☐ Mature
- ☐ Wrinkled
- ☐ Patchy dryness
- ☐ Sallow
- ☐ Psoriasis
- ☐ Dehydrated/Lacking moisture
- ☐ Asphyxiated
- ☐ Telangiectasia/Broken surface capillaries

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What are changes you'd most like to see in your skin?

_____

_____

Lifestyle

Are you pregnant or lactating? □No □Yes
(Please consult with your obstetrician. Only the Oxygenating Trio, Detox Gel Deep Poor Treatment or Hydrate: Therapeutic Oat Milk Mask are appropriate.)

Do you work contact lenses? □No □Yes
(Remove contacts if eyes are sensitive or if having microdermabrasion.)

Do you currently have a sunburned/wind burned/red face? □No □Yes

If yes, why? _____

Are you in the habit of going to tanning booths? □No □Yes
(If within 14 days, decline treatment. This practice should be discontinued due to increased risk of skin cancer and signs of aging.)

Do you participate in vigorous aerobic activity or sports? □No □Yes

If yes, what type? _____

Do you smoke or use tobacco? □No □Yes

What kind of work do you do? _____

On average, how many hours per week do you spend outdoors? _____

Medical/ Treatment History

Do you currently use depilatories or wax? □No □Yes
(Discontinue use 5 days prior and after treatment)

Have you had a chemical peel or any type of procedure with a medical device? □No □Yes
Within the last 14 days? □No □Yes

If yes, what type? _____

Do you have regular collagen, Botox or other dermal filler injections? □No □Yes
(Peels should precede or follow injections by 2 days to prevent movement of the filler or stinging at the injection site.)

Have you recently had laser resurfacing or facial surgery? □No □Yes

If yes, please describe treatment and when _____

_____

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Are you currently taking any medications, topical, or otherwise? □No □Yes
(Tretinoin/ Retin-A/Renova/Differin/Tazorac/Avage/EpiDuo/Ziana)

If yes, which one(s), Strength and how long? _____

_____

(High percentages of certain ingredients may increase sensitivity. Discontinue use five days before and after treatment. Consult your physician before discontinuing use of any prescription.)

Are you currently using any topical retinoid prescription? □No □Yes
Have you ever undergone Accutane therapy (isotretinoin)? □No □Yes
(If you are currently using Accutane Therapy (isotretinoin), please contact your dispensing physician. If you no longer use Accutane Therapy (isotretinoin) it is OK to apply one layer of TCA, Jessner, Enzyme, or other Chemical Peel

Do you develop cold sores/ fever blisters? □No □Yes

Last break out? _____

Are you allergic/sensitive to?:

- □ Milk
- □ Apples
- □ Citrus
- □ Grapes
- □ Aloe Vera
- □ Aspirin
- □ Perfumes
- □ Latex
- □ Hydroquinone
- □ Mushrooms

Any other allergies, what? _____
Have you ever used any other products that caused a bad reaction? □No □Yes

If yes, describe _____

Signature: _____ Date: _____

Signature of Clinician: _____

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Consent Form

Prior to receiving treatment, I have been candid in revealing in any condition that may have bearing on this procedure, such as: pregnancy (if so, consult your physician prior to treatment), recent facial surgery, allergies, tendency to cold sores/fever blister, or use of tropical and/or oral prescription medications such as tretinioin, Retin-A, isotretinoin, Accutane, Differin, Tazorac, Avage, EpiDuo, or Ziana.

I understand there may be some degree of discomfort such as stinging, pin-prickling sensation, heat or tightness.

I understand there are no guarantees as to the results of this treatment, due to many variables, such as: age, condition of skin, sun damage, smoking, climate, etc.

I understand I may or may not actually peel and that each case is individual. I understand that the amount of peeling does not correlate with degree of improvements.

I understand this treatment is a cosmetic treatment and that no medical claims are expressed or implied.

I understand that to achieve maximum results, I may need several treatments.

I understand that although complications are very rare, sometimes they may occur and that prompt treatment is necessary. In the event of any complications, I will immediately contact the physician/clinician who performed the treatment.

I agree to refrain from tanning in tanning beds or outdoors while I am undergoing treatment and during the 14 days, prior to and following the end of treatment. This practice should be discontinued due to the increased risk of skin cancer and signs of aging.

I understand that extended direct sun exposure is prohibited while I am undergoing treatment, and the daily use of sunscreen protection, with a minimum of SPF 30 is mandatory.

I have not had any other chemical peel of any kind within 14 days of this treatment. I understand I cannot have another chemical peel within 14 days of this treatment, whether it is performed at this location or any other location.

I understand that I should follow my clinician's recommendations for post-procedure skin care to minimize side effects and maximize results.

I hereby agree to all of the above and agree to have this treatment performed on me. I further agree to follow all post-peel care instructions as I am directed.

Signature: _____ Date: _____

Initials: _____

Signature of Clinician: _____

Signature of Witness: _____

Continued Treatment Consent

Date	Initials

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PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL PHOTOGRAPHS

I hereby authorize **Unique Wellness Center**, and the staff to take and use before, during, and after procedure or treatment photographs, and/or video recordings for documentation purposes as part of my medical record as well as professional medical purposes deemed appropriate including, but not limited to, showing these images for the purposes of medical education, patient education, lay publication, or during lectures to medical or lay groups.

The use of such photographs and/or video recordings for use in advertisements and marketing campaigns for the practice of **Unique Wellness Center**, including public or commercial television, print media as well as digital media such as internet sites, will not be used without my written permission.

If I authorize the use of such photographs and/or video recordings, my identity and face will be concealed, so that no one would know who I am, unless otherwise authorized by me. I understand that all information regarding my procedures and myself is always kept privileged.

I release and discharge **Unique Wellness Center**, and all parties acting under his/her license and authority from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs.

I certify that I have read the above Authorization and Release and fully understand its terms.

_____ _____

Patient/Guardian Signature **Date**

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INFORMED CONSENT: DERMAPLANING

Please read the following information and acknowledge that you understand and accept all provisions by signing below.

I, _____, acknowledge and understand Dermaplaning is a form of manual exfoliation. A medical grade, sterile blade is stroked along the skin at an angle to gently "shave off" dead skin cells from the epidermis. Dermaplaning also temporarily removes the fine vellus hair of the face, and I may receive added improvements such as reduction in the appearance of fine lines & temporary fading of pigmentation. I acknowledge that the Dermaplaning treatment is not an exact science and that no specific guarantees can or have been made concerning the expected result. I understand that the degree of improvement is variable and maximum results are obtained by participating in a series of treatments plus following a home care regimen. I also acknowledge that due to the contours of the face, certain areas of the face (such as the eyelids and nose) are not treatable using this method.

I understand that if I add glycolic or other chemical peel solutions onto my Dermaplaning treatment that I may achieve greater results, but I will also assume greater risks and have discussed these risks with my skincare therapist.

I understand that with any treatment certain risks are involved and that any complications or side effects from known or unknown causes could occur.

If I am prone to herpetic outbreaks, I understand that I may be advised to see a physician about appropriate prescriptions or supplements to control outbreaks prior to treatments.

I acknowledge that the success of my treatment depends on me and I have an obligation to follow the written and spoken instructions concerning pre and post treatment care in order to achieve optimal results.

I understand multiple treatments are recommended to see optimal results. The cost of treatment has been disclosed to me and I understand that payment is due at the time services are rendered.

I am over 18 years of age or have parental consent form signed and attached.

I will call to inform my skincare specialists of any complications or concerns as soon as they occur.

I have read the contents of this consent form carefully and I fully understand it. I have been given the opportunity for discussion pertaining to Dermaplaning treatments and all my questions have been answered to my satisfaction. I hereby release Unique Wellness Center and any of its employees against any and all liability associated with this procedure. I have been adequately informed of the risks and benefits of this treatment and wish to proceed with the Dermaplaning treatment.

Patient's Name (Printed): _____

Signature: _____ **Date:** _____

Staff Signature: _____ **Date:** _____