

# client treatment authorization form

This is used to evaluate your individual skin care needs. We will maintain the confidentiality of this information and will disclose this information only: (i) to our staff members, (ii) to quality assurance and quality control personnel, (iii) to our product supplier and manufacturer. We will not provide this information to anyone else, except as required by law, and we will not sell this information to anyone. We may, however, contact you with product-related information.

name		birthday
address		apt/unit
city	state	zip
email phone		

- 1 What treatment are you having today?  
 ProSkin     Pro Power Peel     Microneedling  
 NanoInfusion     Dermaplaning     Other  
 IPL     Melanopro
- 2 Within the last year, have you had any health problems that have affected or could affect your skin?  
 yes     no
- 3 Are you prone to keloid scarring, blisters, or cold sores?  
 yes     no
- 4 List any medications, supplements, vitamins, diuretics, oral contraceptives, Isotretinoin, etc. that you take regularly.  
\_\_\_\_\_  
\_\_\_\_\_
- 5 Do you have any other medical condition, or autoimmune diseases such as Lupus, contraindicated by your physician for advanced treatments?  
 yes     no
- 6 Do you wear contact lenses?  
 yes     no
- 7 Do you have metal implants, a pacemaker or body piercings?  
 yes     no
- 8 Do you have any allergies?  
 yes     no  
If yes, please specify: \_\_\_\_\_  
\_\_\_\_\_
- 9 Do you have sinus problems?  
 yes     no
- 10 Have you ever experienced claustrophobia?  
 yes     no
- 11 What are your specific concerns/challenges with your skin?  
\_\_\_\_\_  
\_\_\_\_\_
- 12 What skin care products are you currently using?  
 soap     cleanser     toner     spf     moisturizer  
 masque     exfoliant     eye products     other
- 13 Have you had chemical peels, microdermabrasion or any resurfacing treatments within the last 2 weeks?  
 yes     no
- 14 Have you been waxed within the last 1-2 weeks?  
 yes     no
- 15 Have you used retinol, tretinoin or any other prescription skin products within the last three months?  
 yes     no
- 16 Are you currently using any products that contain the following ingredients?  
 yes     no  
 Glycolic Acid     Lactic Acid     any exfoliating scrubs  
 Other Hydroxy Acids     Vitamin A derivatives (i.e., Retinol)
- 17 Please specify if any of the following apply to you:  
 pregnant     trying to become pregnant     lactating  
 menstruating     pre-menstrual
- 18 Have you received a cosmetic light-based procedure such as laser treatment, IPL, etc. within the last 6 weeks?  
 yes     no
- 19 Do you have active cold sores?  
 yes     no
- 20 Have you received neurotoxin (Botox) injections within the past 2 weeks or other injectable procedures within the past 4 weeks?  
 yes     no
- 21 Do you sunbathe or use tanning beds?  
 yes     no
- 22 Do you experience redness, itching, or stinging on your skin?  
 yes     no

**pro power peel:****Precautions & Warnings**

1. Skin may appear flushed following the treatment.
2. Peeling may begin within 2-3 days. DO NOT pick at loose skin, as this may cause discoloration.
3. Avoid direct sun exposure for 2-3 weeks to prevent hyperpigmentation.
4. Avoid sweaty exercise on the day of treatment, along with steam rooms.
5. Avoid any type of exfoliating product until directed otherwise by Professional Skin Therapist.

**Contraindications for pro power peel:**

- |  |   |
|--|---|
| <input type="checkbox"/> pregnant or nursing women   | <input type="checkbox"/> prone to post-inflammatory hyperpigmentation or keloid scars |
| <input type="checkbox"/> open skin lesions or active cold sores  | <input type="checkbox"/> recent sun exposure  |
| <input type="checkbox"/> recent resurfacing such as laser, microdermabrasion or chemical peel within 2 weeks | <input type="checkbox"/> history of diabetes  |
| <input type="checkbox"/> use of isotretinoin currently or in the past six months                             | <input type="checkbox"/> received cosmetic injectables within 14 days                 |
| <input type="checkbox"/> severe rosacea or acne  |   |

**microneedling:****Precautions & Warnings**

1. Discontinue use of retinoid (Retin-A) and/or any form of skin treatment 3 days prior to procedure, under care and direction of a physician.
2. Not for active acne, rosacea, or other inflammatory skin conditions. Not for skin with piercings in treatment area or open wounds.
3. Not to be administered for 6 months to 1 year after isotretinoin (Accutane) regimen.
4. Not for clients with facial outbreaks such as herpes simplex virus. Medication must be taken per doctor's instructions.
5. Not for clients with metal allergies or skin allergies.
6. Any medications that would affect the characteristics of the skin should be stopped for two months prior to treatment, under the care and direction of a physician.
7. For any recent face lift or eyelid surgery, seek advice from your surgeon regarding how soon you can receive treatment.
8. Not for clients who have had dermabrasion, remodeling, deep chemical peels, or any surgical procedure on the treatment area within the previous 3 months.
9. Not for clients who have had neurotoxin injectable (Botox), or other injectables such as collagen, fat, or other methods of augmentation in the targeted area within 14 days.
10. Not for clients who have sunburned skin from the sun or tanning beds within previous 14 days.
11. Avoid sweaty exercise, sauna, steam, and sun exposure for 3 days post-treatment.
12. Fitzpatrick skin types 4-6; pigment may darken prior to lightening.
13. You may experience redness for up to 3 days.
14. You may experience inflammation, itching, and burning.
15. Consult a physician if any irritation persists.

**Contraindications for microneedling:**

- |   |   |
|---|---|
| <input type="checkbox"/> history of hemophilia, irregular blood pressure, tuberculosis, liver function issues | <input type="checkbox"/> history of eczema, psoriasis and other chronic conditions                              |
| <input type="checkbox"/> susceptibility to capillary ectasia due to steroid use for extended periods          | <input type="checkbox"/> history of actinic (solar) keratosis, diabetes, raised moles or warts on targeted area |
| <input type="checkbox"/> cardiac abnormalities, pacemaker, blood clotting problems                            | <input type="checkbox"/> scleroderma  |
| <input type="checkbox"/> blood thinning medication  | <input type="checkbox"/> collagen vascular disease  |
| <input type="checkbox"/> immunosuppression  | <input type="checkbox"/> active bacterial or fungal infection; (i.e., cold sore)                                |
| <input type="checkbox"/> keloid scars   | <input type="checkbox"/> history of any type of cancer  |
|   | <input type="checkbox"/> pregnant or nursing  |

**nanoinfusion:****Precautions & Warnings**

1. Discontinue use of retinoid (Retin-A) 3 days prior to procedure, under care and direction of a physician.
2. Not for active acne, rosacea, or other inflammatory skin conditions. Not for skin with piercings in targeted area or open wounds.
3. Not for clients with metal allergies or skin allergies.
4. Any medications that would affect the characteristics of the skin should be stopped for two months prior to treatment, under the care and direction of a physician.
5. Not for clients who have had neurotoxin (Botox) injectable, or other injectables such as collagen, fat, or other methods of augmentation in the targeted area within 14 days.
6. No waxing, depilatory creams, or methods of hair removal to the targeted area for at least 5 days prior. No IPL/laser hair removal 14 days prior.
7. Not for clients who have sunburned skin from the sun or tanning bed within previous 14 days.
8. Avoid sweaty exercise, sauna, steam, and sun exposure for 3 days post-treatment.
9. You may experience redness between 1-3 days.
10. You may experience inflammation, itching, and or burning.
11. Consult a physician if any irritation persists.
12. Raised scars, lesions, or moles in the targeted area will not be treated.
13. Seek physician's approval if you are pregnant or nursing.

**Contraindications for nanoinfusion:**

- |   |   |
|---|---|
| <input type="checkbox"/> keloid scars   | <input type="checkbox"/> scleroderma                          |
| <input type="checkbox"/> active eczema, psoriasis, and other chronic condition flare up                         | <input type="checkbox"/> collagen vascular disease            |
| <input type="checkbox"/> history of actinic (solar) keratosis, diabetes, raised moles or warts on targeted area | <input type="checkbox"/> active bacterial or fungal infection |
| <input type="checkbox"/> pregnant or nursing  | <input type="checkbox"/> history of any type of cancer        |

**dermaplaning:****Precautions & Warnings**

1. Discontinue products containing any exfoliating agents and active ingredients such as retinol 3 days before treatment.
2. Not for client with facial outbreaks such as herpes simplex virus. Medication must be taken per physician's instructions.
3. Skins prone to post inflammatory hyperpigmentation (PIH): skin brightening home care pre and post service is advised.

**Contraindications for dermaplaning:**

- |   |  |
|---|--|
| <input type="checkbox"/> current, inflamed acne lesions | <input type="checkbox"/> use of Accutane currently or in the past six months |
| <input type="checkbox"/> skin cancer                    | <input type="checkbox"/> use of prescription Retinol within the past 3 days  |
| <input type="checkbox"/> active cold sores              |  |
| <input type="checkbox"/> uncontrolled diabetes          |  |
| <input type="checkbox"/> dermatitis                     |  |
| <input type="checkbox"/> open skin lesions              |  |

**melanopro peel system:****Precautions & Warnings**

1. Avoid contact with the eyes, lips, and mucous membranes. In case of accidental contact, wash thoroughly with water.
2. Not recommended for children under the age of 18.
3. Do not use products with AHAs, BHAs, enzymes, exfoliants or Retinol during the treatment.
4. Make-up may be applied once any redness from the application of the Melanopro Peel System has stopped.
5. Avoid sun exposure during the home care program.
6. History of diabetes. Ensure there is no current active health concerns with healing or any complications with peels in past services.

**Contraindications for melanopro peel system:**

- This system is not advised for those with highly sensitive skin or those who have skin conditions such as rosacea, eczema, psoriasis, etc.
- Not for use on those that have sunburned skin.
- Not for use on pregnant or nursing clients.
- Not for use on those with active cold sores.
- Not for use on those with open skin lesions.
- Not for those currently using Isotretinoin in the past 6 months.
- Not for those prone to keloid scars.
- Not for use on those who have had injectables in the past 14 days.

**IPL:****Precautions & Warnings**

1. Not for clients who have excessively tanned or sunburned skin from the sun, tanning beds, or tanning creams within previous 4 weeks.
2. Discontinue photosensitizing medications, such as Accutane (Isotretinoin), at least 6 months before treatment. Discontinue medications such as Retin-A, Renova, and Tazorac 3-7 days before treatment.
3. Discontinue waxing, chemical depilatories and chemical peels on the treatment area within 1-2 weeks of treatment.
4. Shave dark hair or prevalent vellus hair 12-24 hours before treatment.
5. IPL is not recommended for melanin-rich skin (Fitzpatrick skin types 4 and higher). Please consult your physician for approval to receive treatment.
6. Avoid sweaty exercise, sauna, steam, and sun exposure for 3 days post-procedure.
7. You may experience redness for up to 3 days.
8. You may experience tightness, inflammation, itching and burning.
9. Pigmentation may appear darker after treatment. Avoid picking or scrubbing skin for 1-2 weeks, as it can cause scarring.
10. Consult a physician if any irritation persists.

**Contraindications for IPL:**

- |   |   |
|---|---|
| <input type="checkbox"/> epilepsy or history of seizures  | <input type="checkbox"/> active infections (e.g. herpes simplex)  |
| <input type="checkbox"/> lupus  | <input type="checkbox"/> use of Accutane currently or in the past six months                                |
| <input type="checkbox"/> use of photosensitizing medications (including some antibiotics)       | <input type="checkbox"/> use of diabetes medication   |
| <input type="checkbox"/> use of St. John's Wort within the past 3 months                        | <input type="checkbox"/> use of Vitamin A or hydroxy acids within the past 3 days                           |
| <input type="checkbox"/> areas with permanent make-up or tattoos (including cosmetic)           | <input type="checkbox"/> presence of a pacemaker  |
| <input type="checkbox"/> vitiligo   | <input type="checkbox"/> presence of surgical metal pins or plates under targeted area                      |
| <input type="checkbox"/> pregnant or nursing  | <input type="checkbox"/> use of blood-thinning agents (i.e. Aspirin, Ibuprofen, Aleve) within the past week |
| <input type="checkbox"/> cancer   |   |
| <input type="checkbox"/> history of keloid scars  |   |
| <input type="checkbox"/> severe dermatitis, active inflammatory acne or eczema on targeted area |   |

# client consent

I understand that results will vary between individuals. I understand that although I may see a change after my first treatment, I may require a series of sessions to obtain my desired outcome.

The procedure contraindications, precautions and warnings have been explained to me including alternative methods, as have the advantages and disadvantages.

I am advised that though good results are expected, the possibility and nature of complications cannot be fully anticipated.

Therefore, there can be no guarantee as expressed or implied either as to the success or other result of the treatment. I am aware that the results of this treatment with Dermalogica are not permanent as natural degradation will occur over time.

I have read this consent form and I understand the information contained in it.

I have had the opportunity to ask any questions about the treatment, including risks or alternatives and acknowledge that all my questions about the procedure have been answered in a satisfactory manner.

I confirm that the information I have provided on this form is accurate, to the best of my knowledge, and that I have not withheld any information that will be relevant to my consultation.

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 signature

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 date

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 skin therapist signature

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 date