BEYOND TRANQUILITY SPA

10411 Reserve Drive, San Diego, CA 92127
858-829-1776

SKIN HISTORY and CONSENT FORM

Name ______________________ **D.O.B** ______________________

Address ______________________ **City** ______________________ **State** ________

Zip ____________ **Mobile** ( ) - ________ **Home** ( ) - ________

Occupation ______________________ **Referred by** ______________________

Email ______________________________

DO YOU HAVE ANY HEALTH PROBLEMS? (CHECK ALL THAT APPLY)

Heart Problems Hormonal Problems High/Low Blood Pressure Diabetes Skin Cancer Allergies (list) ______________________

	YES	NO
ARE YOU PREGNANT OR LACTATING?		
DO YOU HAVE ROSACEA? *If so, for what?*		
DO YOU GET COLD SORES/FEVER BLISTERS ON FACE/LIPS? *If yes, how often?*		
DO YOU HAVE ANY IMPLANTS? *Pacemaker, pins in bones, etc.*		
DO YOU WEAR CONTACT LENSES?		
ANY RECENT SURGERIES? *If yes, please explain:*		
ARE YOU TAKING ACCUTANE?		
ARE YOU USING RETINOIDS? *If so, which ones?*		
ARE YOU USING TOPICAL MEDICATIONS? *If so, which ones?*		
ARE YOU USING EXFOLIATING ACIDS? *If so, which ones?*		
ARE YOU TAKING ANY OTHER MEDICATIONS? *If so, which ones?*		
HAVE YOU HAD AN ADVERSE REACTION TO A PRODUCT? *If so, which product or ingredient gave you the reaction?*		
HAVE YOU HAD TREATMENT FROM A DERMATOLOGIST? *If so, for what condition(s)?*		

WHEN WAS THE LAST TIME YOU RECEIVED A FACIAL? ____________

WHAT PRODUCTS/BRANDS ARE YOU USING?

CLEANSER: ______________________

SOAP GEL CREAM/MILKY OTHER ____________

TONER/ASTRINGENT ______________________

FACIAL SCRUBS ______________________

SUNSCREEN ______________ SPF # ________

ARE YOU HAPPY WITH THE RESULTS? ____________

DESCRIBE YOUR HISTORY OF SUN EXPOSURE: ____________

____

HOW DO YOU WANT TO IMPROVE YOUR SKIN? PLEASE LIST SPECIFIC AREAS YOU WANT TO TREAT. **FACE, NECK, CHEST, HANDS, OTHER**

____

____

ALLERGIES TO: LAVENDER ALOE VERA SHEA BUTTER

NOTES: ______________________________

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Please carefully review the information you have provided. If you have a specific medical condition or symptoms, certain esthetic treatments may be contraindicated and a referral from your primary care physician will be required prior to services being rendered. I, the undersigned, understand that the services I am receiving are provided for the basic purpose of relaxation. If I experience any discomfort during the session, I will immediately inform the esthetician. Because some procedures relating to skincare such as peels, diamond dermabrasion, body treatments and wraps should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all the questions honestly. I agree to keep the esthetician updated as to any changes in my medical profile and understand that there shall be no liability on the esthetician's part should I fail to do so. I am authorizing *Beyond Tranquility* and the esthetician, to perform facial services/bodywraps. I relieve *Beyond Tranquility* from any liability resulting from an adverse reaction to any of the services provided.

Client Printed Name ______________________ Date ____________

Client Signature ______________________ Date ____________

Esthetician Signature ______________________ Date ____________

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Chemical Peel Procedure Consent

I have given an accurate account of any over the counter or prescription medications that I use regularly, and I am not presently using, nor have I used within the last 6 months, Isotretinoin/Accutane (thins the skin), Retin-A (causes dryness, peeling, redness, and stinging) Acyclovir/Zovirax (makes the skin prone to rashes), or tranquilizers (causes susceptibility to infection). ______
client initials

I have not had any facial procedures, or other chemical peels that I have not disclosed to my esthetician. I am not ingesting or using topically any other over the counter product or prescription medication/agent not listed above.

______
client initials

I am not presently pregnant or lactating and I am over the age of eighteen (18). ______
client initials

I have not had any recent radioactive or chemotherapy treatments, sunburn windburn, or broken skin. I have not recently waxed or used a depilatory (such as Nair) on the area being treated. I do not have a history of keloidal scarring, diabetes, any autoimmune disease, active herpes blisters, or any other existing condition that may interfere with the positive outcome of this treatment. _____
client initials

I consent to the taking of photographs to monitor treatment results, as desired or recommended by my esthetician. ______
client initials

My expectations are realistic. I understand that results aren't guaranteed. For maximum results, multiple treatments are required and the rate of improvement depends on age, skin type/condition, degree of sun/environmental damage, pigmentation, or acneic condition. ______
client initials

I understand that this procedure is expected to make the skin feel uncomfortable while being applied, but I agree to inform the skin professional immediately if I have concerns or am overly uncomfortable during treatment or after I return home. ______
client initials

I agree that I am willing to follow recommendations made by my esthetician for home care. I will be responsible for following home regimens that can minimize or eliminate possible negative reactions. I recognize the importance of wearing a sunscreen and avoiding the sun/tanning booths and extreme weather conditions after this procedure is performed. I agree to use a moisturizer specially recommended by my esthetician and I acknowledge that I have been informed of the possible negative reactions (intense erythema, welts, scabs) and the expected sequence of the healing process (dryness, irritation, redness, and peeling of the skin). In the event that I may have additional questions or concerns regarding my treatment or suggested home product/post treatment care, I will consult my therapist immediately. ______
client initials

I understand the potential risks and complications and have chosen to proceed with the treatment after careful consideration of the possibility of both known and unknown risks, complications, and limitations. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosure. I certify that I have read, and fully understand the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered. ______
client initials

I have read the above information and initialed each section to indicate that I fully understand what to expect. If I have any questions or concerns, I will address these with my esthetician. I give permission to my esthetician ____________________________, to perform the chemical treatment we have discussed and will hold her from any liability that may result from this treatment. I understand she will take every precaution to minimize or eliminate negative reactions such as blisters, sores, or other reactions. ______
client initials

____
Client Name (printed) Date

____
Client Signature Date

____
Esthetician Signature Date