

# 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  
☐ NanoInfusion      ☐ Dermaplaning  
☐ Microneedling      ☐ Other

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      ☐ 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

SHINESALON

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 or steam rooms.
- 5. Avoid any type of exfoliating product until directed otherwise by Professional Skin Therapist.

Contraindications for pro power peel:

- ☐ pregnant or nursing women
- ☐ open skin lesions
- ☐ active cold sores
- ☐ use of isotretinoin currently or in the past six months
- ☐ severe rosacea or acne
- ☐ prone to post-inflammatory hyperpigmentation or keloid scars
- ☐ recent sun exposure
- ☐ history of diabetes

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 excessively tanned or sunburned skin from the sun, tanning beds, or tanning creams 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:

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

nanoinfusion:

Precautions & Warnings

- 1. Discontinue auto-immune therapies or retinoid 9Retin-A) and/or any form of active skin care product 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 excessively tanned or sunburned skin from the sun, 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 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:

- ☐ keloid scars
- ☐ active eczema, psoriasis, and other chronic condition flare up
- ☐ history of actinic (solar) keratosis, diabetes, raised moles or warts on targeted area
- ☐ pregnant or nursing
- ☐ scleroderma
- ☐ collagen vascular disease
- ☐ active bacterial or fungal infection
- ☐ 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.

Contraindications for dermaplaning:

- ☐ current, inflamed acne lesions
- ☐ skin cancer
- ☐ active cold sores
- ☐ uncontrolled diabetes
- ☐ dermatitis
- ☐ open skin lesions
- ☐ use of Accutane currently or in the past six months
- ☐ use of prescription Retinol within the past 3 days

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.

signature

date

skin therapist signature

date