



## CLIENT CONSULTATION AND RELEASE FORM

***Please read carefully, complete, sign and date this form prior to your treatment.***

Name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Email: \_\_\_\_\_

- HYDRAFACIAL™     BLUE LED LIGHT THERAPY     RED LED LIGHT THERAPY  
 LYMPHATIC/MASSAGE THERAPY     WET DIAMOND (Medical Use Only)  
 MICRODERMABRASION

**SECTION 1: MEDICAL INFORMATION**

- Do any of the following conditions relate to you?

<b>Do you have any of the following allergies?</b>	
Shellfish Aspirin Sulfur Preservatives	Other (Please list): _____ _____ _____

YES	NO	Contraindications
<input type="checkbox"/>	<input type="checkbox"/>	Accutane or other similar medication
<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune disease, HIV, lupus, hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Blood thinners – Heparin, Coumadin, Warfarin, etc.
<input type="checkbox"/>	<input type="checkbox"/>	Breast feeding, pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	Cancer or post-cancer treatments
<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular problems
<input type="checkbox"/>	<input type="checkbox"/>	Cold sores or fever blisters without pre-medication
<input type="checkbox"/>	<input type="checkbox"/>	Cortisone or steroid injections
<input type="checkbox"/>	<input type="checkbox"/>	Cosmetic injections, fillers or implants, (i.e. Botox®, collagen)
<input type="checkbox"/>	<input type="checkbox"/>	Eczema, psoriasis
<input type="checkbox"/>	<input type="checkbox"/>	Enlarged or painful glands
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Facial waxing services w/in 7-14 days
<input type="checkbox"/>	<input type="checkbox"/>	Heart ailment
<input type="checkbox"/>	<input type="checkbox"/>	Hypertension/high blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	Inflammatory conditions
<input type="checkbox"/>	<input type="checkbox"/>	Irregular, pigmented moles, warts or growths, unidentified facial growth or mark
<input type="checkbox"/>	<input type="checkbox"/>	Keloids, pigmented scars, icepick scars, new scar tissue
<input type="checkbox"/>	<input type="checkbox"/>	Laser procedures, chemical peels, dermabrasion, microdermabrasion
<input type="checkbox"/>	<input type="checkbox"/>	Light sensitive medication

**EDGE SYSTEMS LLC.**

2277 Redondo Avenue, Signal Hill, CA 90755 United States 1.800.603.4996 Toll-Free 1.562.597.0102 T 1.562.597.0148 F

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YES	NO	Contradictions
<input type="checkbox"/>	<input type="checkbox"/>	Loose, thin, aged skin
<input type="checkbox"/>	<input type="checkbox"/>	Lymphatic disorder, inflammation of lymph vessels, lymphedema
<input type="checkbox"/>	<input type="checkbox"/>	Medication, list here:
<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker or metal implants
<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis, varicose veins
<input type="checkbox"/>	<input type="checkbox"/>	Recent accident or serious injury
<input type="checkbox"/>	<input type="checkbox"/>	Recent surgical or dental procedure
<input type="checkbox"/>	<input type="checkbox"/>	Rosacea, telangiectasia/couperose
<input type="checkbox"/>	<input type="checkbox"/>	Retin-A, Retinol
<input type="checkbox"/>	<input type="checkbox"/>	Skin abrasions or lesions
<input type="checkbox"/>	<input type="checkbox"/>	Stage III or IV acne
<input type="checkbox"/>	<input type="checkbox"/>	Skin-lightening or bleaching agent
<input type="checkbox"/>	<input type="checkbox"/>	Sunburn
<input type="checkbox"/>	<input type="checkbox"/>	Swollen or infected tonsils
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid conditions
<input type="checkbox"/>	<input type="checkbox"/>	Type I diabetic
<input type="checkbox"/>	<input type="checkbox"/>	Under medical care for an existing or suspected condition or disease
<input type="checkbox"/>	<input type="checkbox"/>	Viral infection, influenza
<input type="checkbox"/>	<input type="checkbox"/>	Other contraindication at discretion of skincare technician or medical practitioner:

- If you answered **YES** to any of the above questions please explain:

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- My interest in skincare treatment is primarily for (i.e. skin rejuvenation, acne, hyperpigmentation, scarring, etc.)

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- Specify your areas of concern (i.e. eyes, forehead, etc.)

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## SECTION 2: CLIENT CONSENT FORM

*(Initial each acknowledgement line below)*

1. I acknowledge that I have not used Accutane or any medication for the same purpose during the last 12 months. \_\_\_\_\_*(initial here)*
2. I acknowledge that if I have ever had a cold sore or fever blisters, I should consult with my physician or pharmacist for a pre-use medication to help avoid a possible breakout. That medication should be used each day for two days before, same day, and two days after any aggressive facial exfoliation treatment. \_\_\_\_\_*(initial here)*
3. I acknowledge that there is no guarantee that dark discoloration of skin will be reduced or fade. Pigmentation may improve or darken with successive treatments. I acknowledge the need for proper skin care home regimen. \_\_\_\_\_*(initial here)*

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4. I acknowledge that my skin might experience temporary irritation, tightness, redness or slight swelling which usually dissipates within 72 hours depending on skin sensitivity. \_\_\_\_\_(initial here)
5. I have disclosed my history of allergies above. \_\_\_\_\_(initial here)
6. I acknowledge that if I am allergic to one or more of the ingredients in the products used, I may experience allergic reactions. \_\_\_\_\_(initial here)
7. I acknowledge that if I fail to use a minimal sunscreen (SPF 30) and follow the direction for use, I am more susceptible to sunburn, sun damage & hyperpigmentation. I should avoid excessive sun exposure, especially between 10am - 2pm. \_\_\_\_\_(initial here)
8. I acknowledge that this treatment is strictly an elective cosmetic procedure and that no medical claims have been expressed or implied. \_\_\_\_\_(initial here)
9. I acknowledge that I should avoid use of aggressive exfoliation, waxing, and products containing acids that are not part of the recommended take-home regimen for 2-4 weeks following the treatment. \_\_\_\_\_(initial here)
10. I acknowledge that I should avoid use of Retin-A type products for a period of time recommended by my physician and/or skincare practitioner during and following the treatment. \_\_\_\_\_(initial here)
11. I acknowledge that I am not pregnant/lactating. \_\_\_\_\_(initial here)
12. I hereby agree to have the treatment performed and agree to follow all pre and post treatment instructions. \_\_\_\_\_(initial here)
13. I acknowledge that I have answered all questions truthfully and completely. \_\_\_\_\_(initial here)
14. I release Edge Systems, the \_\_\_\_\_ (Aesthetician/Doctor), management and staff of \_\_\_\_\_ (Clinic/Office) from any and all liability associated with any injuries and/or current or future conditions resulting from the skincare procedures or products. \_\_\_\_\_(initial here)
15. I consent to the use of my before, during and after facial procedure photographs for education, promotion or advertising purposes. My name will not be used to identify these photographs without my written approval. \_\_\_\_\_(initial here)

By signing below, I certify that I have read and fully understood the contents of this consent form, and that the information I provided above are complete, accurate, and up-to-date to my knowledge.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Operator Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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