

Last Name: _____ First Name: _____ Middle Initial: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Evening Phone: _____ Daytime Phone: _____ Cell: _____
Email: _____ Occupation: _____
Date of Birth: _____ Anniversary: _____
Genetic origin: African American ___ Asian ___ Caucasian ___ Hispanic ___ Mediterranean ___ Middle Eastern ___ Native American ___ Other ___
How did you hear about us? Postcard ___ Billboard ___ Walk-in ___ Facebook ___ Twitter ___ Online search ___ Email ___
Other: _____ Friend: _____

Medications:

List all medications, including prescription and over-the-counter drugs, vitamins, herbs and supplements: _____
Are you using any medications purchased outside the USA? Yes ___ No ___
Are you allergic to any medications? Yes ___ No ___
Please list all medications and their reactions: _____

Pregnancy:

When is your expected due date? _____
Number of pregnancies? _____
Number of births? _____
Is this your first prenatal massage? Yes ___ No ___ My last was: _____
Are you having a high-risk pregnancy? Yes ___ No ___ If yes, explain: _____
Please indicate any of the following that you have or had during pregnancy:
Headaches ___ Sinus congestion ___ Morning sickness ___ Heartburn ___ High blood pressure ___ Low blood pressure ___
Thyroid problems ___ Varicose veins ___ Hemorrhoids ___ Constipation ___ Diarrhea ___ Pre-term labor ___

Medical History (please check all that apply):

Arthritis ___ High blood pressure ___ Bruising ___ Sciatic pain ___ Scoliosis ___ Seizures or Epilepsy ___ Disc degeneration ___
Fever ___ General fatigue ___ Lupus ___ Heart attack ___ Cramps ___ Blood clots ___ Severe PMS ___ Raised leg veins ___
Asthma ___ Chronic fatigue syndrome ___ Fibromyalgia ___ Depression ___ Osteoporosis ___ Chronic Sinusitis ___ Spinal problems ___
Past shoulder surgery, year: _____ Past broken bone, year: _____, location: _____ Swelling, location: _____
Bursitis, location: _____ Open abrasions, location: _____ Headaches, type: _____ Cancer, type: _____
Heart surgery, year: _____ Pregnancy, weeks: _____ Rotator cuff tear, right/left: _____

Please answer the following questions:

1. Are you currently being treated for any medical condition? Yes ___ No ___ If yes, explain: _____
2. Have you ever seen a physician regarding your skin? Yes ___ No ___
3. Do you have any active skin diseases or infection in the area to be treated? Yes ___ No ___
4. Do you have any skin allergies? Yes ___ No ___
5. Have you had skin cancer or pre cancerous lesions? Yes ___ No ___
6. Do you have psoriasis/eczema in the area to be treated? Yes ___ No ___
7. Are there any moles with hair in the area to be treated? Yes ___ No ___
8. Are you allergic to latex, lidocaine, or any lotions? Yes ___ No ___
9. Have you ever surgery in the area to be treated? Yes ___ No ___
10. Have you had any previous laser treatments or other skin treatments to the area to be treated? Yes ___ No ___
11. Have you /are you using medications such as Accutane? Yes ___ No ___ If yes, date of last use: _____
12. Are you using Retin-A, Renova, Differin, Tazorac? Yes ___ No ___ If yes, concentration percentage: _____
13. Are you using Glycolic/AHA home care products? Yes ___ No ___
14. What skin care products are you currently using? _____
15. Do you smoke? Yes ___ No ___
16. Do you sunbathe? Yes ___ No ___ If yes, date of last sun exposure: _____
17. Are you currently using, or have you used a tanning bed or self tanner? Yes ___ No ___ If yes, date of last use: _____
18. Do you use a sunscreen? Summer: _____ SPF: _____ Winter: _____ SPF: _____
19. Do you use facial depilatories? Yes ___ No ___ Hot Wax? _____
20. Does your skin remain discolored after healing from a cut? Yes ___ No ___

Skin Concerns:

Aged skin ___ Sun damage ___ Rosacea ___ Age spots ___ Acne ___ Enlarged pores ___ Blackheads ___ Texture ___
Redness ___ Wrinkles ___ Whiteheads ___ Stretch marks ___ Leg veins ___ Hair removal ___ Oily skin ___ Skin laxity ___
Spider veins ___ Unevenness ___ Dry skin ___ Scars ___ Scarring ___ Hyper-pigmentation ___ Sensitive skin ___ Melasma ___

What areas would you like to treat? Face/neck ___ Chest ___ Arms ___ Hands ___ Back ___ Legs ___ Other _____

Please indicate any services you would like to receive or learn more about:

Laser skin rejuvenation ___ Rosacea treatment ___ Acne treatment ___ Laser vein treatment ___ Sun damage repair ___
Age spot treatment ___ Laser hair removal ___ BOTOX® Cosmetic ___ Skin tightening ___ Pigment treatment ___ Filler injections ___
Stretch mark/scar treatment ___ Wrinkle treatment ___ Redness/vessels treatment ___ Melasma treatment ___

As a Pure Luxe Salon, Spa & Medspa client, you will be provided with the opportunity to review your treatment with the professional(s) responsible for your care before receiving treatment of any kind. You will be advised of the manner in which treatment will be provided, the risks involved and any alternative that is available for your consideration and will be given the opportunity to ask questions. By executing this form, you agree that the sales representative has reviewed treatment with you and answered your questions. Your attending professional will review this form with you a second time prior to your initial treatment and will sign this form in the space provided to indicate that you have been given a second opportunity to ask questions of a professional.

_____ I understand this treatment is a cosmetic treatment and that no medical claims are expressed or implied. I understand that to achieve maximum and continued results the protocol recommended by Pure Luxe should be followed.

_____ I understand there are no guarantees implied as to the results of this treatment, due to many variables, such as: age, skin type, skin condition, sun damage, smoking, alcohol, environmental exposures, etc.

_____ I understand that I may or may not actually see demonstrable visible results, that each case is individual.

_____ I acknowledge that I have been candid in revealing any condition which might have an effect on this treatment, such as: pregnancy, medications, previous or recent skin surgery or treatment, skin cancer, cold sores/fever blisters, allergies, use of Retin-A, Accutane, Differin or hormones.

_____ I understand that direct sun exposure is prohibited while I am undergoing treatment. The use of sunblock protection with a minimum SPF of 30 is recommended. I agree to refrain from skin tanning in tanning booths while I am undergoing treatment, and during the 14 days following my last treatment.

_____ If I am prone to Herpetic outbreaks around the mouth, I have been advised to see my physician for a prescription for Acyclovir or Zovirax.

_____ I acknowledge my skin might experience temporary tightness, redness or slight swelling which usually dissipates within 24 hours depending on skin sensitivity.

_____ I agree to refrain from any skin care treatment, cosmetic or medical, 14 days preceding and 14 days following any treatment with Pure Luxe, including filler injections and BOTOX® Cosmetic treatments.

_____ I agree to avoid the use of glycolics, AHA's, or Retin-A type products for 2-5 days following this treatment.

_____ I understand that I will not be allowed to have laser treatments during any pregnancy. My unused treatments will be placed on hold.

_____ I understand with any treatment certain risks are involved and complications and/or side effects from know or unknown cause could occur. I freely assume these risks.

_____ I am over 18 years of age or have parental consent co-signed below.

_____ I will call my practitioner and inform them of any complications or concerns as soon as they occur.

I have read and understand this agreement and all my questions have been addressed and answered to my satisfaction. I consent to the terms of this agreement.

Client Name: _____

Signature: _____

Witness: _____

Date: _____

I, the undersigned medical professional, hereby certify that I have reviewed the foregoing treatment consent with the named patient (including the risks of and alternatives to treatment) on or prior to the first date of treatment and have given the patient the opportunity to ask questions regarding his or her treatment, including the opportunity to communicate with a physician.

Professional: _____ Date: _____