CLIENT INFORMATION SHEET

NAME________________________________ DATE OF BIRTH______________________

ADDRESS___________________________________ CITY:________________________

STATE:_____________ ZIP:___________ OCCUPATION:_____________________________

EMAIL:____________________________ REFERRED BY:____________________________

PHONE:(DAY)_______________________ (NIGHT)________________________________

PROCEDURES DESIRED: BOTOX: ___FOREHEAD ___CROWS FEET ___FROWN LINES (BETWEEN EYES),OTHER____

DERMAL FILLERS: ___LIPS ___NASOLABIAL FOLDS ___UNDER EYES ___OTHER

MASSAGE: ___

PERMANENT MAKEUP: ___EYELINER ___EYEBROWS ___LIPLINE ___FULL LIP COLOR ___NIPPLES ___BEAUTY MARK ___SKIN REPIGMENTATION

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN? ___YES ___NO

IF SO, WHY?________________________ PHYSICIAN'S NAME____________________________

MEDICATIONS:_____________________________________ ALLERGIES:____________________

DO YOU HAVE ANY OF THE FOLLOWING: ___DIABETES ___HEPATITIS ___HEART PROBLEMS ___HEMOPHILIA ___SKIN PROBLEMS

___SCARRING (KELOIDS) ___EYE PROBLEMS ___EPILEPSY ___OTHER & EXPLAIN:____

ARE YOU PREGNANT OR NURSING? _______ DO YOU WEAR CONTACT LENSES? ____________

SIGNED____ DATE______________________

cloud 9 MEDI SPA

SKIN HEALTH QUESTIONNAIRE & CONSENT

NAME____ D.O.B.____________________________

E-MAIL:_____________________________________ REFERRED BY:_____________________

PHONE:____________________________________ OCCUPATION:_______________________

HAVE YOU BEEN TREATED FOR: (PLEASE CIRCLE)

ACNE   DEPRESSION   SKIN DISEASE   HIGH BLOOD PRESSURE   COLD SORES   DIABETES   CANCER

DESIRED TREATMENT:____

ALLERGIES____

MEDICATIONS YOU ARE TAKING____

ARE YOU PREGNANT? __________ TRYING TO GET PREGNANT? __________

HORMONE THERAPY?__________ HAVE YOU EVER HAD A COLD SORE?__________

WHEN YOU GO OUT IN THE SUN, DO YOU (CIRCLE ONE):
ALWAYS BURN   USUALLY BURN   SOMETIMES BURN   RARELY BURN
VERY RARELY BURN   NEVER BURN

HAVE YOU EVER BEEN UNDER THE CARE OF A:

DERMATOLOGIST _____ PLASTIC SURGEON _____ AESTHETICIAN _____

ARE YOU CONCERNED ABOUT SKIN CONDITIONS ON YOUR BODY? (CIRCLE ALL THAT APPLY) SUN SPOTS   SKIN LAXITY   DRY/ROUGH AREAS

WHAT SKIN LINE PRODUCTS ARE YOU CURRENTLY USING?

____

DO YOU USE DAILY ENVIRONMENTAL PROTECTION (SUNBLOCK)? __________

IF NOT, WHY?

____

CIRCLE HOW YOU FEEL ABOUT THE OVERALL QUALITY OF YOUR SKIN:
(BAD) 1 2 3 4 5 6 7 8 9 10 (FANTASTIC)

YOUR SKIN TYPE IS:
NORMAL DRY/DEHYDRATED OILY ACNE/ACNE PRONE ROSACEA

SKIN CONDITION (PLEASE SELECT ALL THAT APPLY)

_____SUPERFICIAL WRINKLES _____ROSACEA _____ACNE OR ACNE PRONE
_____DEHYDRATION
_____HYPERPIGMENTATION (SUN OR BROWN SPOTS) _____ACNE SCARS
_____SEVERE PHOTOAGING _____UNBALANCED

IN ORDER OF IMPORTANCE, PLEASE RANK 1 (MOST IMPORTANT) TO 5 (LEAST IMPORTANT) IMPROVMENT IN THE NEXT 30 DAYS:
_____REDUCTION OF FINE LINES
_____REDUCTION OF BROWN SPOTS/SUN DAMAGE
_____REDUCTION OF OIL/ACNE
_____REDUCTION OF REDNESS
_____ACNE SCARS DIMINISHED

PRECAUTIONS

THE TREATMENT YOU WILL RECEIVE IS A CLINICAL TREATMENT DESIGNED TO EXFOLIATE OR REMOVE THE OUTER LAYERS OF THE SKIN.

TYPE OF PEEL TO BE PERFORMED: SLICYLIC RETINOL GLYCOLIC (70% OR LESS) 99% GLYCOLIC JESSNER VI / GREEN TCA: 10% 15% 20% 30%

YOUR PARTICIPATION IN YOU R SKIN CARE TREATMENTS WILL DETERMINE THE OUTCOME. IT IS IMPORTANT THAT YOU STRICTLY ADHERE TO YOUR HOME CARE PRODUCTS THAT YOU R ESTHETICIAN RECOMMENDED.

NO GUARANTEE IS EXPRESSED OR IMPLIED AS TO THE PRECISE RESULTS, PEELING TIMES OR DISCOMFORT.

DEPENDING ON THE TREATMENT, YOU MAY EXPERIENCE SOME TEMPORARY STINGING OR WARM FLUSHING. THIS WILL FADE WITHIN 5 MINUTES. DURING THE NEXT FEW HOURS, YOU MAY EXPERIENCE SOME TIGHTENING OF THE SKIN, WHICH MAY LAST FOR SEVERAL DAYS.

FOR MOST PATIENTS, A LIGHT FLAKING BEGINS WITHIN 48 HOURS. IT IS IMPOSSIBLE TO PRE-DETERMINE HOW MUCH PEELING WILL OCCUR. THE SHEDDING PROCESS USUALLY SUBSIDES WITHIN 5-7 DAYS.

PLEASE INITIAL (PLEASE READ CAREFULLY)

_____I AGREE TO AVOID DIRECT SUN EXPOSURE FOR 2 WEEKS

_____I AM NOT PREGNANT.

_____I AGREE TO USE IMAGE POST PEEL KIT _____I AM NOT ALLERGIC TO ASPIRIN

_____I AGREE TO NOTIFY CLOUD 9 OF ANY CONCERNS

_____I AGREE NOT TO PICK / PEEL OR SCRATCH SKIN DURING THE HEALING PHASE

_____I AGREE TO APPLY IMAGE SOLAR DEFENSE DAILY

_____I DO NOT HAVE ACTIVE COLD SORES

_____I AGREE NOT TO WAX FOR 1 WEEKHOURS PRE/POST TREATMENT

_____I HAVE NOT TAKEN ACCUTANE IN THE PAST YEAR

_____I AGREE NOT TO USE RETIN-A PRODUCTS 5 DAYS PRE/POST TREATMENT

_____I HAVE NOT USED GLYCOLIC FOR 24 HOURS

_____I AGREE TO F/U WITH SCHEDULED APPOINTMENT

*EXCEPTION 4-LAYER FACE LIFT AND PASSION PEPTIDE PEEL SAFE FOR PREGNANT WOMEN

CONSENT (PLEASE SIGN)

I HEREBY GIVE MY CONSENT AND AUTHORIZATION VOLUNTARILY AND RELEASE Cloud 9 medi spa FROM ANY CLAIMS, IMPLIED OR STATED THAT I HAVE OR MAY HAVE IN THE FUTURE WITH THIS TREATMENT, REGARDLESS OF RESULT. I AM STATING THAT THE TREATMENT AND PRECAUTIONS ABOVE HAVE BEEN EXPLAINED TO ME IN DETAIL AND THAT I FULLY UNDERSTAND.

CLIENT SIGNATURE____ **DATE**___________

CLOUD 9 REP:____ **DATE**___________