PASC
PACIFIC ADVANCED SKIN CARE

{805} 473. 7311
www.pacificadvancedskincare.com
1353 Shell Beach Road, Pismo Beach, CA 93449

Contact Information:

Date: _____ Date of Birth: _____ Gender: ◯ Male ◯ Female

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work/Day Phone: _____ Cell: _____

Email: _____

Emergency Contact: _____ Emergency Contact Phone: _____

Medical Background

Ethnic Skin Type:

◯ Caucasian ◯ African-American ◯ Hispanic ◯ Asian ◯ East Indian ◯ American Indian

Please list any health conditions you are experiencing: _____

Have you ever taken or are currently taking: ◯ Retin A ◯ Accutane

Topical or Oral Antibiotics: ◯ Oral ◯ Topical · What is the name of the antibiotic? _____

How often do you exercise? _____

What is your level of stress? Low 1 2 3 4 5 6 7 8 9 10 High

How many hours of sleep do you get per night? _____

How many 8 oz. glasses of water do you drink each day? _____

How much caffeine and/or alcohol do you consume each day? Caffeine: _____ Alcohol: _____

Do you smoke? ◯ Yes ◯ No

Please list all supplements, medications, allergies or recent surgeries:

_____

How much UV exposure do you get (sun, tanning beds, commuting in car): _____

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Client Self Assessment

Do you have any of the following: ◯ Scars ◯ Stretch Marks ◯ Hyper Pigmentation

Do you suffer from:

◯ Acne ◯ Blackheads ◯ Whiteheads ◯ Milia ◯ Oiliness
◯ Rosacea ◯ Dehydration ◯ Eczema ◯ Cellulite
◯ Vein/Circulation Problems ◯ Psoriasis Where: _____

◯ Other _____

Have you ever received any of the following treatments?

◯ Facial ◯ Microdermabrasion ◯ Laser Surgery ◯ Chemical Peels
◯ Waxing ◯ Lash/Brow Tint ◯ Laser Hair Removal ◯ Vein Treatments

Please select the box that applies to you?

◯ I never tan, always burn ◯ I tan with difficulty, usually burn
◯ Average tanning, Sometimes burn ◯ Easily tan, rarely burn
◯ I never burn

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*****Pacific Advanced Skin Care and Pamela Thoring do not perform any pre-cancerous skin exams, nor, will be held liable for any cancerous lesions not identified during your esthetic procedure*****

CLIENT INFORMED CONSENT TO TREATMENT

I, _____ consent to and authorize Pacific Natural Medical Centre & Advanced Skin Care Inc. to perform skin exfoliation, skin waxing, facials, and other related skin care services.

Services Performed Today: _____

- I have not used a scrub, Retin-A, Retinol A, take home micro-dermabrasion or glycolic peels in the last 72 hours. _____ (Initial)
- The nature and purpose of the treatment has been explained to me and any questions I may have regarding the procedure has been explained to my satisfaction. _____ (Initial)
- I understand that with any treatment certain risks are involved and that any complications or side effects from known or unknown causes could occur. I freely assume these risks. _____ (Initial)
- I have no allergies to Iodine (Seaweed). _____ (Initial)
- I am not Epileptic and do not have heart or circulation problems. _____ (Initial)
- Possible side effects include, but are not limited to mild redness, extreme redness, bruising, local selling, stinging, tenderness, dry skin, flaking, lightening or darkening of the skin, infections, pimples, bumpy appearance, and cold sores. Most side effects are temporary and generally fade within 72 hours. (Chemical Peels) _____ (Initial)
- If prone to cold sores, see your physician about a prescription for Aycloovair, Zorvirax, or take supplements of Olive Leaf, L-Lysine along with Beta Carotene, and Folic Acid daily. _____ (Initial)
- It is recommended to discontinue use of all AHA, Glycolics, Retin-a, Renova, or any exfoliating products for up to 72 hours post procedure. Using hydrating, soothing, antioxidants for healing and ice for swelling and inflammation reduction. No sun exposure or tanning beds for 72 hours and use at least a SPF 15 sunscreen daily when receiving treatments is recommended. _____ (Initial)
- I agree to adhere to all safety precautions and home skin care program as recommended by Pacific Natural Medical Centre & Adv. Skin Care Inc. _____ (Initial)
- I am over 18 years of age, or I have a parental consent co-signed below. _____ (Initial)
- I will call to inform Pacific Natural Medical Centre & Adv. Skin Care Inc. of any complications or concerns I may have as soon as they occur. _____ (Initial)
- I have been off of Accutane for at least 12 months. _____ (Initial)

I have voluntarily elected to undergo this treatment/procedure after the nature and purpose of this treatment has been explained to me, along with the risks and hazards involved.

Although, it is impossible to list every potential risk and complication, I have been informed of possible benefits, risks, and complication. I also recognize there are no guaranteed results and that independent results are dependent upon age, skin condition, and lifestyle and that there is the possibility I may require further treatment of the treated areas to obtain the expected results at an additional cost.

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I have read and understand the post-treatment home care instructions. I understand how important it is to follow all instructions given to me for post-treatment care. In the event that I may have additional questions or concerns regarding my tretament or suggested home product/post-treatment care. I will consult the esthetician immediately. (Pamela's Cell: 805-441-5669)

I have also, to the best of my knowledge, given an accurate account of my medical history, including all known allergies or prescription drugs or products I am currently ingesting or using topically.

I have read and fully understand this agreement and all information detailed above. I understand the procedure and accept the risks. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. I do not hold the esthetician, responsible for any of my conditions that were present, but not disclosed at the time of this skin care procedure, which may be afftected by the treatment performed today.

Client Name (Signature): _____

Date: _____

Consent to Treatment of Minor:
By my signature below, I hereby authorize Pacific Natural Med. Centre & Adv. Skin Care, Inc., to treat my child or dependent, as they deem necessary.

Signature of Parent/Guardian: _____

Date: _____

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WAXING INTAKE FORM

Contact Information:

Date: _____ Date of Birth: _____ Gender: ◯ Male ◯ Female

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work/Day Phone: _____ Cell: _____

Email: _____

Emergency Contact: _____ Emergency Contact Phone: _____

Medical Background

1. Do you have any of the following conditions?

◯ Diabetes ◯ Cancer ◯ High Blood Pressure ◯ Acne ◯ Asthma
◯ Hemophilia ◯ Heart Problems ◯ Pace maker ◯ Phlebitis ◯ Hepatitis
◯ Autoimmune diseases such as lupus ◯ Addison's Disease ◯ Arthritis

**If you have any of these medical conditions, please provide a note from your doctor indicating his or her approval for you to have a waxing service.*

2. Are you pregnant? ◯ Yes ◯ No If you are preganat, when is the baby due? _____

**If you are pregnant, please provide a doctor's note stating that it is safe to have waxing services performed on you.*

3. Have you used Accutane in the last seven years? ◯ Yes ◯ No
If you are currently using Accutane, you cannot receive a waxing treatment.

4. Are you currently taking

Prednisone	◯ Yes	◯ No
Antibiotics	◯ Yes	◯ No
Coumadin	◯ Yes	◯ No

* Please provide a Dr. note if you are taking any of these.

5. Are you currently using one of these topical acne/wrinkle creams?

◯ Retin A ◯ Renova ◯ Differin ◯ Azelex ◯ Tazorac

**If you are using any one of these topical creams, waxing may cause sensitivity, redness, skin abrasion, skin removal, or other skin problems.*

6. List any medications you are taking. Include all prescription medications and over-the-counter medicines, such as Aspirin, Tylenol, Advil, and antacids.

_____

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7. Are you allergic to any medications? ◯ Yes ◯ No

If yes, please list them: _____

ARE YOU ALLERGIC TO ANYTHING? PLEASE LIST: _____

8. List all vitamins, supplements, herbs, and teas you take or drink regularly:

_____

9 .(OPTIONAL) Last menstrual period ended: _____
We recommend not having a bikini wax or Brazilian bikini wax during menstruation. Also, for other face and body waxing your skin will be more sensitive during menstruation.

10. Are you taking any pills/medications or are you applying anything to your skin that might or is supposed to make it peel? ◯ Yes ◯ No
Please list any medication, cream, or other item that you take or apply that may make your skin peel:

_____

11. Have you had any changes in your health or medications since your last visit?
EXAMPLE: Botox shot on 8/1/06, 8/2/10:

_____ Date: _____ Date _____ Date _____

_____ Date: _____ Date _____ Date _____

Beauty Treatments:

1. Do you use any products with the following ingredients?
◯ Salicylic acid ◯ Alpha-hydroxy acid ◯ Vitamin C ◯ Enzymes
**Any of these acids will make your skin more sensitive when being waxed and may cause skin removal. Stop using these ingredients 48-73 hrs. before and after your waxing treatment.*

2. Have you ever had ◯ laser treatment ◯ chemical peel ◯ other facial treatment
Please describe this treatment and give the date(s)

_____

3. Have you ever had a Botox shot? ◯ Yes ◯ No
If yes, please note where on the face and the date of injection: _____

Have you ever had a Restylane, Radiance, or collagen injection? ◯ Yes ◯ No
If yes please note facial location, date and type of injection: _____

* Please wait 72 hrs. after a Botox, Restylane, Radiance, or collagen injection before waxing between the eyes or in the area of the injection.

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4. Have you been in the sun or in a tanning bed within the last 48 hrs.? ◯ Yes ◯ No

Do you have a sunburn? ◯ Yes ◯ No

5. Have you ever had an adverse reaction after hair removal? ◯ Yes ◯ No
If yes, specify the type of hair removal and the adverse reaction you had:

WHAT IS YOUR PREFERRED METHOD OF HAIR REMOVAL?

I have answered all of the questions to the best of my knowledge. I understand that the professional may refuse to provide epilation services because of certain health conditions and that it is in my best interest if the service is not provided. I also understand that there may be swelling or irritation in the areas that are waxed or otherwise epilated. This is a only temporary condition. If a doctor's note is required, I must provide the note to the beauty professional before the waxing service. I understand that it is my duty to notify the beauty professional of any changes to my health, medications, or beauty treatments. In the event that I neglect to notify Pacific Advanced Skin Care of any health, medications, or beauty treatment changes, I cannot hold Pacific Advanced Skin Care responsible for any damage, harm, injury, adverse reaction suffered by me as a result of receiving waxing or any other beauty treatment service. By checking the YES box, I indicate that I release Pacific Advanced Skin Care from any liability.

◯ Yes

Please sign below. If the client is under the age of 18, a parent or guardian signature is required.

Client Signature:	Date:
Parent/Guardian Name (please print)	Parent/ Guardian Signature