Skin Deep Electrology
123 Green Street
Woodbridge, NJ 07095
phone: (908) 343-3863

www.SkinDeepElectrology.com
SkinDeepElectrology@gmail.com

Client Health History Assessment

Client Number:
electrolysis office use only

Primary Information

Today's Date: MM / DD / YYYY Date of Birth: MM / DD /YYYY

Legal First Name: _____ Middle Initial: _____ Legal Last Name: _____

Preferred Name: _____ Gender Identified as: _____ Prounouns: She/Her He/Him They/Them

Street Address: _____ City: _____ State: _____ Zipcode: _____

Phone: home /mobile ( ) _____ Email: _____

Hair Removal Information

Areas you are considering for treatment? {select all that apply}

Head: Lip / Mustache Chin Beard Eyebrows Unibrow Ears {outside} Sideburns Hairline Neck

Body: Armpits Breast / Chest Navel / Happy Trail Bikini / Groin Anus Penis Shaft Upper Back Lower Back

Limbs: Shoulders Upper Arms Lower Arms Hands Fingers Outer Thighs Inner Thighs Lower Legs Feet Toes

Other: _____

Hair Removal Methods

What hair removal methods do you most frequently use? {select all that apply}

Shaving Waxing Sugaring Tweezing Creams Laser Threading Other: _____

Have you ever had electrolysis before? yes / no Date of last treatment: _____

Modality: {select all that apply} Thermolysis Blend Galvanic Not Sure

Have you ever had a negative effect from a hair removal method? yes / no

Please Explain: _____

Health Information

List All Medications & Vitamins You are Currently Taking:

Name	Purpose	Name	Purpose

List All Allergies:

Name	Comments	Name	Comments

Health Conditions Present or Past: {select all that apply}

Acne Body Piercings Beathing Problems Cancer Cardiovascular Disease Clotting Issues Cold Sores COPD Covid-19
Diabetes Dizziness / Fainting Heart Attack Healing Issues Hepatitus Herpes High Blood Pressure HIV Infertility
Metal Implants Keloids Kidney Disease Pacemaker PCOS TB Thyroid Disease Skin Tags Stroke Warts
Other: _____

Client Health History Assessment

Are you pregnant: yes / no **Do you get your period:** yes / no **If yes, is it regular:** yes / no

Have you traveled outside of the country in the last 30 days: yes / no **Where:** _____

Have you had any major surgeries? yes / no **Specify:** _____

Are you preparring for sex reassignment surgery? yes / no **Planned Date of Surgery:** MM / DD / YYYY

Other Information

How did you hear about us? Website Facebook Instagram Pinterest Google Referral ... who? _____

Other: _____

Media release

Does Skin Deep Electrology have permission to document your hair removal process through your story, pictures and or videos and use them in its print and/or digital publications? **Photographs:** yes / no **Videos:** yes / no

If you circled yes above read the following & initial below. If no, continue to 'Client Acknowledgement Section'

By circling yes above, you grant permission to Skin Deep Electrology, LLC. to post my and/or my child's electrolysis hair removal journey/story in the media formats circled and initaled above, hereinafter referred to as "Materials," on the Skin Deep Electrology website {www.skindeepelectrology.com}, Instagram account {@skindeepelectrology}, Facebook account {@skindeepelectrology} and any other print or digital media accounts used to represent, market and/or brand Skin Deep Electrology, LLC.

I hereby release you, your representative, employees, managers, members, officers, parent companies, subsidiaries, and directors, from all claims and demands arising out of or in connection with any use of said "Materials", including, without limitation, all claims for invasion of privacy, infringement of my right of publicity, defamation and any other personal and/or property rights.

I acknowledge and agree that no sums whatsoever will be due to me as a result of the use and/or exploitation of the "Materials" or any rights therein.

Initials: _____

Client Acknowledgement of Information

I understand health history information is important to my Electrologist in order to provide me with safe and effective electrology treatments. I acknowledge all information given by me is accurate to the best of my knowledge, and I agree to update my health history assessment whenever there are changes.

I understand that a series of treatments is necessary to achieve permanent hair removal and my progress will be impacted by my personal hair growth rate, the science of electrology, and my individual physiological factors.

I understand my electrologist has the right to refuse treatment if it is not beneficial to my health or skincare due to known or unknown health conditions I may have.

Client Name: _____ Signature: _____ Date: MM / DD / YYYY

If under 18, parent/guardian must sign.

Parent's Name: _____ Parent's Signature: _____ Date: MM / DD / YYYY