STATERA
Integrated Health & Wellness Solutions

Aesthetics Intake and Consent Form

Name: **Date:**

Address:

Best Phone #:
Email:
How did you hear about us? Birth Date:
Emergency Contacts: Age:
Option 1: Phone #:
Option 2: Phone #:

Health/Medical *(Please answer to best of your knowledge)*

Physician's name, address, and phone number:
Please list all medications that you take regularly. Include hormones, vitamins, etc:

Please circle any health conditions which you have had in the past or are now experiencing:

Cancer	**Pregnant / Nursing**	**Epilepsy**	**Seizures**
HIV	**Phlebitis**	**Hemophilia**	**Thrombosis**
Hepatitis	**Light/Photo Sensitivity**	**Heart Condition**	**Bleeding Disorder**
Recent Illness	**Recent Surgery**	**Lupus**	**Taking Blood Disorder Medication**
Pacemaker	**Taking Isotetrinoin (Accutane)**	**Claustrophobia**	**Diabetes**
Metal Implants/Screws	**Allergies to silicone or stainless steel**	**Thyroid Disorders**	**Muscular Conditions**
			High/Low Blood Pressure
Implanted Neurostimulation Devices	**Lack of Normal Skin Sensation**		

Allergies:

Is there anything else you would like us to be aware of:

Have you ever undergone treatment from a Dermatologist? ☐No ☐ Yes

If yes, when?
What type of condition?
Any negative side effects?

Have you ever undergone treatment from an Esthetician? ☐No ☐ Yes

If yes, when?
What type of condition?
Any negative side effects?

Within the last month, have you taken or used any of the following?

Retin A	☐	Antibiotics	☐	Diuretics	☐
Accutane	☐	Oral Contraceptives	☐	Laxatives	☐

Have you ever undergone plastic surgery? ☐No ☐ Yes
If yes, when?
Where on your body?
What information can you provide about the procedure?

Nutrition/Diet

Check the types of fluids that you consume daily and indicate the amount per day:

Water	☐	Juices	☐	Tea	☐
Coffee	☐	Alcohol	☐	Sodas	☐

Home Skin Care Regimen

Describe (using product brand names) how you are presently caring for your skin:

	AM	PM		AM	PM
Cleanser:			Exfoliant:		
Toner:			Serum:		
Moisturizer:			SPF Sunscreen:		
Make-Up			Other:		

How many hours do you sleep per night?

How often do you exercise?

On a Scale from 1 (low) to 10 (high) how would rate your stress?

How much sun exposure have you had?

Do you have specific concerns about your skin?

How long have you noticed your condition?

Is this an ongoing or temporary condition?

What specific improvements do you wish to see?

Have you ever received a salon/spa skin care treatment?

What were the results?

Previous aesthetic treatments, please check all that apply

Botox / Dysport / Date:	Dermal Fillers: Restylane/Juvaderm/Sculptra Date:	Facials Date:	Laser Treatments Date:
IPL/Photorejuvenation Date:	Chemical Peels Date:	Microdermabrasion Date:	Microcurrent Date:
LED Light Therapy Date:	Microexfoliation Treatment Date:	Facial Waxing: Date:	Other: Date:

Liability Release, Informed Consent

Liability Release and Informed Consent to Receive Service

Caution: M*icrocurrent* will not be performed if any of the following conditions exist: Any severe health conditions, or any of the following contraindications: Cancer, Epilepsy, History of Seizures, Pacemaker, Pregnancy, HIV, Thrombosis or Phlebitis or conditions that are unknown. A physician must be consulted for any medical questions.

Caution: Mi*crodermabrasion* applications will not be performed if any of the following conditions exist: Any severe health conditions or any of the following contraindications: any contagious disease, any drug causing sun sensitivity (Tetracycline), any drug or application causing thinning of skin (Retin-A or Accutane), blood transmitted diseases (HIV, Hepatitis, Herpes), Hemophilia, or conditions that are unknown. A physician must be consulted for any medical questions.

Caution: *LED light* applications will not be performed if any of the following conditions exist: Any severe health conditions or any of the following contraindications: Hypersensitivity to light or "photo allergy," tendency toward photo-toxic reactions, taking of photo-sensitizing or photo-toxic medication, Cancer, HIV, Epilepsy, History of Seizures, Lupus, Pregnancy, or conditions that are unknown. A physician must be consulted for any medical questions.

Caution: Microexfoliation will not be used on individuals with: cancer, open wounds, sores, lesions, irritated, or damaged skin, is pregnant or nursing pregnancy, any contagious or transmittable disease, a hemorrhagic (bleeding) disorder or hemostatic (bleeding) dysfunction, taking blood disorder medications, allergy to stainless steel, silicone, or anesthetics, or currently taking drugs with the ingredient isotetrinoin (such as Accutane).

I certify that the above statements are true and correct, and that I, ..., having been advised and fully informed by the service provider concerning the nature of the process to be performed by them, the risks and benefits of the process, and the risks and benefits of not having the process performed, hereby authorize and direct the service provider to perform such process and perform such services as may be deemed necessary or advisable. My signature below constitutes my acknowledgement that:

(1) I have read, understand and fully agree to the foregoing;

(2) Understand the caution and contraindications for each process and service proposed;

(3) Give consent to the proposed process that has been satisfactorily explained to me and I have all the information that I desire

Client Full Printed Name _____ Date _____

Client Signature, Or Signature of Legal Guardian if Client is a Minor _____ Date _____

Intake Taken By: Full Printed Name _____ Date _____

Intake Signature _____ Date _____

CONDITION	Yes	No
Cancer		
Pregnancy		
Epilepsy		
Seizures		
Lupus		
Diabetes		
Phlebitis/Thrombosis		
HIV / Herpes / Hepatitis (indicate which)		
Medications		
Retin A, AHA, Tetracycline, Accutane		
Pacemaker / Implanted Neurostimulator		
Other		
CLIENT SIGNATURE	**DATE**	