

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

1. Do you currently get regular facial treatments? YES NO How often? \_\_\_\_\_
2. Have you ever had chemical peels, laser, or microdermabrasion? YES NO  
In the last month YES NO If yes, please list: \_\_\_\_\_
3. Do you use Retin-A, Renova, Adapalene Hydroxyl Acid, Accutane, or Retinol/Vitamin A derivative products, or any other Topical Prescriptions? YES NO If yes, please list: \_\_\_\_\_
4. Are you taking any medications? YES NO If yes, please list: \_\_\_\_\_
5. Do you work outside or spend a lot of time outdoors, if so please explain? \_\_\_\_\_
6. Are You Pregnant or Breastfeeding? \_\_\_\_\_
7. Do you have sinus issues? \_\_\_\_\_
8. What brand of facial make-up do you wear? \_\_\_\_\_
9. Do you smoke or have you in the past? YES NO If yes, how much per day? \_\_\_\_\_
10. List any known allergies \_\_\_\_\_
11. Stress level 1 – 10 \_\_\_\_\_
12. Do you have an allergic reaction to insect bites? YES NO If yes, please explain: \_\_\_\_\_
13. Have you had any recent cosmetic procedures? YES NO If yes, please list: \_\_\_\_\_
14. How Sensitive would you rate your skin 1-5? (1 *Extremely Sensitive* – 5 *Not Sensitive at all*) \_\_\_\_\_
15. Which of the following best describes your skin type? (Please circle one I, II, III, IV, V, VI)  
*I Creamy complexion - Always burns easily, never tans II Light Complexion - Always burns, tans slightly*  
*III Light/Matte Complexion - Burns moderately, tans gradually IV Matte Complexion - Seldom burns, always tans well*  
*V Brown Complexion - Rarely burns, deep tan VI Black Complexion - Never burns, deeply pigmented*
16. Describe your current skin care routine & product brand.  
Cleanser \_\_\_\_\_ Scrub \_\_\_\_\_ Toner \_\_\_\_\_  
Moisturizer \_\_\_\_\_ Sun Block \_\_\_\_\_ Other \_\_\_\_\_
17. What areas of concern do you have regarding your Skin: (Please check any that apply and explain)  
**Eyes:** o dehydrated o wrinkles o puffiness o dark circles o Other: \_\_\_\_\_  
**Face:** o Breakouts/acne o Blackheads/whiteheads o Excessive oil/shine o Rosacea  
o Broken capillaries o Redness/ruddiness o Sun spot/liver spot/brown spot o Other  
\_\_\_\_\_

I, \_\_\_\_\_, have read and fully understand the below information and initialed each section. If I have any questions or concerns regarding my skin treatments during and after treatment, I will address these with my Aesthetician. I give permission to my Aesthetician, \_\_\_\_\_, to perform the PROLINE chemical treatment we have discussed and will hold him/her harmless from any liability that may result from this treatment. I understand my Aesthetician will take every precaution to minimize or eliminate possible reactions such as blisters, sores, or other reactions as much as possible. I understand that, although rarely, permanent damage can occur such as but not only hypopigmentation or hyper-pigmentation.

I have given all information of any over the counter or prescription medications that I use regularly, and I am not presently using (nor have I used in the last year) isotretinoin (Accutane), excessive Retin-A. I have not had any recent facial surgeries, injectables, permanent cosmetics or other chemical peels that I have not disclosed to my skin therapist. If am currently pregnant or lactating, I am allowing my Aesthetician to perform these chemical treatments at my own risk and will not hold him/her liable for any negative reactions. I am over the age of eighteen (18). I have not had a any recent radioactive or chemotherapy treatments, sunburn, windburn or broken skin. I have not recently waxed or used a depilatory on the area to be treated. I am not currently being treated for any autoimmune disease, diabetes, active herpes blisters or any other existing condition that may interfere with the positive outcome of this treatment. \_\_\_\_\_. I understand that I should not have a chemical peel if I intend to continue to have excessive sun exposure. It has been explained to me that treated area will be more sensitive to the sun and other environmental factors as a result of the treatment and will require use of mineral sunscreen (DERMA-CEUTIX Anti-Aging SPF 35). \_\_\_\_\_.

I consent to the taking of photographs to monitor treatment effects, as desired to recommended by my Aesthetician \_\_\_\_\_.

I understand that the results expected may not be guaranteed and that for maximum results, more than one application may be required. The rate of improvement of my skin depends on my age, skin type and condition, degree of sun/environmental damage, pigmentation levels, or acne condition. \_\_\_\_\_.

I understand that this chemical treatment is expected to make the skin feel uncomfortable during the actual process but agree to inform the Aesthetician immediately if I have any concerns during the treatment and after I return home. \_\_\_\_\_.

For best results and minimizing possible reactions, I will be responsible for following a home care regimen given to me by my Aesthetician, including recognizing the importance of adhering to sunscreen and avoiding the sun/tanning booths and extreme weather conditions. I agree to use a moisturizer specifically recommended by my Aesthetician and I acknowledge that I have been informed of the possible negative reactions (intense erythema, welts, scabs, chemical burn) and the expected sequence of the healing process(dryness, irritation, redness, flaking and peeling of the skin).

If I may have additional questions or concerns regarding my treatment or suggested home care/post treatment care, I will consult my Aesthetician immediately \_\_\_\_\_.

In the event of a highly negative reaction and the involuntary absence of my Aesthetician, I am responsible for contacting my Primary Care Physician to seek treatment and possible medication to treat adverse reaction\_\_\_\_\_.

I understand the potential risks and complications and have chosen to proceed with the treatment after careful consideration of the possibility of both known and unknown risks, adverse reactions, and limitations. I agree that this constitutes full disclosure, and that it replaces any previous verbal or written disclosures. I certify that I have read and fully understand the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered.

Client Name (printed) \_\_\_\_\_ Client Name (signed) \_\_\_\_\_

Aesthetician (printed) \_\_\_\_\_ Aesthetician (signed) \_\_\_\_\_

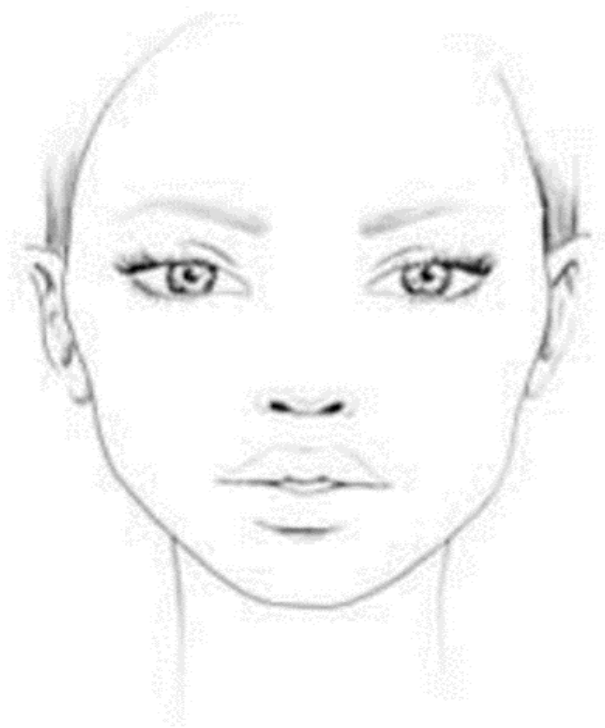
Date \_\_\_\_\_

**For Aesthetician**

Notes:

Treatment Plan:

Home Care Products:



**Forehead:** \_\_\_\_\_  
\_\_\_\_\_

**Eyebrows:** \_\_\_\_\_  
\_\_\_\_\_

**Eyelids:** \_\_\_\_\_  
\_\_\_\_\_

**Undereye:** \_\_\_\_\_  
\_\_\_\_\_

**Cheeks:** \_\_\_\_\_  
\_\_\_\_\_

**Marionette Lines:** \_\_\_\_\_  
\_\_\_\_\_

**Lips:** \_\_\_\_\_  
\_\_\_\_\_

**Chin:** \_\_\_\_\_  
\_\_\_\_\_

**Neck:** \_\_\_\_\_  
\_\_\_\_\_