IMAGE SKINCARE

ALAN WILLIAMS SALON

Age later™

CONFIDENTIAL SKIN HEALTH QUESTIONNAIRE

PATIENT/CLIENT INFORMATION

DATE ______
NAME ______
ADDRESS ______
CITY/STATE/ZIP ______
HOME PHONE ______
WORK PHONE ______
CELL ______
EMAIL ______
OCCUPATION ______
REFERRED BY ______

MEDICAL INFORMATION

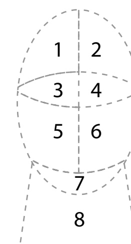
DATE OF BIRTH ______ AGE ______ FAMILY PHYSICIAN ______
DO YOU SMOKE? ______ HOW OFTEN? ______ LIVING WITH A SMOKER? ______
HAVE YOU BEEN TREATED FOR: (PLEASE CHECK)
○ ACNE ○ DEPRESSION ○ SKIN DISEASE ○ HIGH BLOOD PRESSURE
○ COLDSORES ○ DIABETES ○ CANCER
LIST OF ALL ALLERGIES/ALLERGIC ______
LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING ______
ARE YOU PREGNANT? ______ TRYING TO GET PREGNANT? ______ HORMONE THERAPY?
ARE YOU PRONE TO COLD SORES? ______

PERSONAL INFORMATION

CIRCLE YOUR CURRENT LEVEL OF STRESS: 1 2 3 4 5 6 7 8 9 10
CIRCLE YOUR NORMAL LEVEL OF STRESS: 1 2 3 4 5 6 7 8 9 10
HOW MANY OUNCES OF WATER DO YOU DRINK DAILY? ______ DO YOU TAKE SUPPLEMENTS/VITAMINS? ______
DO YOU EXERCISE? ______ IF SO, HOW OFTEN: ______ YOUR LAST SUNBURN? ______ DO YOU USE TANNING BEDS? ______
WHEN YOU GO OUT INTO THE SUN, DO YOU (CIRCLE CHECK ONE):
○ ALWAYS BURN (I) ○ USUALLY BURN (II) ○ SOMETIMES BURN(III) ○ RARELY BURN (IV) ○ VERY RARELY BURN (V) ○ NEVER BURN (VI)
HAVE YOU EVER BEEN UNDER THE TREATMENT PLAN OF A:
○ DERMATOLOGIST ○ PLASTIC SURGEON ○ ESTHETICIAN ○ WOULD YOU BE INTERESTED IN COSMETIC SURGERY? ______
IF YES, WHAT PROCEDURE? ______

ARE YOU CONCERNED ABOUT SKIN CONDITIONS ON YOUR BODY? (CHECK ALL THAT APPLY)
○ SUN SPOTS ○ SKIN LAXITY ○ DRY / ROUGH
WHAT SKIN LINE ARE YOU CURRENTLY USING? ______
DO YOU USE A DAILY ENVIRONMENTAL PROTECTION PRODUCT (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? (PLEASE CHECK ONLY ONE):
○ NORMAL ○ DRY/DEHYDRATED ○ OILY ○ ACNE/ACNE PRONE ○ ROSACEA
IN ORDER OF IMPORTANCE, PLEASE RANK 1 (MOST IMPORTANT) TO 5 (LEAST IMPORTANT) IMPROVEMENT IN THE NEXT 30 DAYS:
____ REDUCTION OF FINE LINES
____ REDUCTION OF BROWN SPOTS/SUN DAMAGE
____ REDUCTION OF OIL/ACNE
____ ACNE SCARS DIMINISHED
____ REDUCTION OF REDNESS



○ 1 LEFT FOREHEAD ○ 5 LEFT CHEEK
○ 2 RIGHT FOREHEAD ○ 6 RIGHT CHEEK
○ 3 LEFT EYE AREA ○ 7 CHIN
○ 4 RIGHT EYE AREA ○ 8 NECK

TREATMENT PLAN (TO BE COMPLETED BY PHYSICIAN/ESTHETICIAN)

PROFESSIONAL TREATMENT RECOMMENDATION
○ ORMEDIC LIFT ○ LIGHTENING LIFT PEEL ○ ACNE LIFT PEEL ○ IMAGE PERFECTION LIFT PEEL
○ SIGNATURE LIFT ○ WRINKLE LIFT PEEL ○ BETA LIFT PEEL ○ TCA ORANGE PEEL

THANK YOU FOR COMPLETING THIS CONFIDENTIAL QUESTIONNAIRE.
THIS INFORMATION WILL ALLOW YOUR PROFESSIONAL SKIN CARE SPECIALIST TO PROVIDE THE OPTIMUM IMAGE PRODUCTS AND SERVICES.

SIGNATURE: ______ DATE: ______

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INFORMED CONSENT FOR IMAGE TREATMENTS

PATIENT/CLIENT INFORMATION

DATE ______________________
NAME ______________________
ADDRESS ______________________
CITY/STATE/ZIP ______________________

HOME PHONE ______________________
WORK PHONE ______________________
CELL ______________________
EMAIL ______________________
FAX ______________________

TREATMENT (Please initial by each statement)

______ The treatement was explained to me in detail.

______ The benefits of what I can realistically expect to see from my Clinical Peel have been fully explained to me.

TREATMENT (Please select one)

______ ORMEDIC LIFT
______ SIGNATURE LIFT
______ LIGHTENING LIFT
______ WRINKLE LIFT
______ ACNE LIFT
______ BETA LIFT
______ IMAGE PERFECTION LIFT
______ TCA ORANGE PEEL

SKIN CONDITION (Please select all that apply)

______ SUPERFICIAL WRINKLES, FINE LINES
______ DEEP WRINKLES, FINE LINES
______ ACNE OR ACNE PRONE
______ DEEP HYPERPIGMENTATION (SUN OR BROWN SPOTS)
______ SEVERE PHOTOAGING
______ ROSACEA
______ DEHYDRATION
______ ACNE SCARS
______ UNBALANCED

PRECAUTIONS (Please Read Carefully)

The Treatment you will receive is a clinical treatment designed to exfoliate or remove the outer layers of the skin.

Your participation in your skin care treatments will determine the outcome. It is important that you strictly adhere to your home care products that your esthetician has recommended.

No guarantee is expressed or implied as to the precise results, peeling times or discomfort.

During the treatment, you may experience some temporary stinging or warm flushing. This will fade within a few minutes. During the next few hours, you may experience some tightening of the skin, which may last for several days.

For most patients, 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.

Depending on the clinical peel performed and your skin quality, the following reactions may occur in some patients:
1) Prolonged redness, irritation & flakiness 2) Dryness and sensitivity 3) Severe allergic reactions in rare instances

PLEASE INITIAL (Please Read Carefully)

______ I AM NOT PREGNANT.**
______ I AM NOT ALLERGIC TO ASPIRIN.
______ I HAVE NOT USED GLYCOLIC FOR 24 HRS.
______ I HAVE NOT USED RETINOL PRODUCTS FOR 72 HRS.
______ I HAVE NOT TAKEN ACCUTANE IN THE PAST YEAR.
______ I AGREE NOT TO PICK, PEEL, OR SCRATCH THE SKIN DURING HEALING PHASE.
______ I AGREE THERE MAYBE CRUSTING & SHEDDING OF SKIN.
______ A PRIOR PATCH TEST HAS BEEN GIVEN TO ME TO RULE OUT ANY ALLERGIC TENDENCIES.
______ I AGREE THAT I CURRENTLY DO NOT USE HYDROCORTISONE.

** EXCEPTION ORMEDIC LIFT & SIGNATURE LIFT SAFE FOR PREGNANT WOMEN.

______ I DO NOT HAVE ACTIVE COLD SORES.
______ I HAVE NOT RECEIVED RADIATION TREATMENTS.
______ I AGREE IT IS MANDATORY TO USE IMAGE POST PEEL KIT.
______ I AGREE TO AVOID DIRECT SUN EXPOSURE FOR 2 WEEKS.
______ I AGREE TO NOTIFY DR/AESTHETICIAN OF ANY CONCERNS.
______ I AGREE TO APPLY IMAGE PREVENTION+.
______ I AGREE NOT TO WAX FOR 7 DAYS PRE/POST TREATMENT.
______ I AGREE TO FOLLOW UP WITH SCHEDULED APPOINTMENT.
______ I AGREE NOT TO USE RETIN-A PRODUCTS 5 DAYS PRE/POST TREATMENTS
______ I AM UNDER THE SUPERVISION OF A PHYSICIAN AND HAVE DISCUSSED THE TREATMENT PLAN WITH MY PHYSICIAN.

CONSENT (Please sign)

I hereby give my consent and authorization voluntarily and release ______________________ (Name of business) 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:** ______________________

WITNESS: ______________________ **DATE:** ______________________