**Body Beautiful Consultation Form**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender M/F:\_\_\_\_\_\_\_ Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthdate:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason For visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check the following about your **Medical History:**

\_ Current medication, pain killers

& antibiotics. \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_ Diabetes. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_ Fertility Drugs or potential of \_ Menopausal. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 pregnancy. \_\_\_\_\_\_\_\_\_\_\_\_ \_ Menstrual Irregularities. \_\_\_\_\_\_\_\_

\_ Blood thinners ( Aspirin, Heparin, \_ History of cancer.\_\_\_\_\_\_\_\_\_\_\_\_

Coumadin). \_\_\_\_\_\_\_\_\_\_\_\_\_ \_ Autoimmune Disorder. \_\_\_\_\_\_\_\_\_

\_ Sun sensitivity.\_\_\_\_\_\_\_\_ \_ Recent Surgery. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_ Previous laser or \_ Allergies. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

peel treatments. \_\_\_\_\_\_\_\_\_\_\_\_ \_ Gold Therapy/Vita A injections.

\_ Sun exposure in the last \_ Dermal fillers or Botox . \_\_\_\_\_\_\_\_

four weeks. \_\_\_\_\_\_\_\_\_\_\_ \_ Blood Clotting.\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_ Self-tanner or \_High Blood pressure or meds. \_\_\_\_\_\_\_\_\_\_

 Aromatherapy. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_ History of Keloid Scars. \_\_\_\_\_\_\_\_

\_ Chlorine Pools. \_\_\_\_\_\_\_\_\_\_ \_ Hormone Problems. \_\_\_\_\_\_\_\_\_\_\_

\_ Cold Sores. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_ Metal Pins. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_ Currently using/have used (please circle): \_ Dental work ( excessive Metal/Fillings)

.Accutane/ Glycolic Acid, Retinoic Acid,

.Hydroquinone, Cortisone cream, Gold

\_ Any other medical concerns \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Skin Care Regimen:**

Please list the name and brand of products that you are currently using.

\_\_Cleanser:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_Sunscreen:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Toner:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ Moisturizer:\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Exfoliation:\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Technician Signature\_\_\_\_\_\_\_\_\_\_\_\_

 **BODY BEAUTIFUL**  **Consent Form:**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby duly authorize a Body Beautiful Certified Technician to perform cosmetic procedures on me using the Inno-pen (micro-needling) for wrinkles, hyperpigmentation, skin Rejuvenation, dyschromia ,melasma, enlarged pores, deeper product penetration, surgical scars, and acne scarring I understand that results vary from patient to patient, depending upon skin color, severity of condition being treated or realistic expectations of a individual.

I understand and acknowledge that the risks that may occur with this particular procedure may include the following: please initial

**For Micro needling**

\_\_ Normal side effects (redness, swelling, itchiness, and dryness) and although rare, abnormal side effects (prolonged redness, itching, swelling, allergic reaction, color change, discomfort and scaring.)

**For Chemical Peel**

\_\_ Normal side effects (redness, swelling, itchiness, and dryness) and abnormal side effects (bruising, scabbing, hyperpigmentation and hypopigmentation.)

**For Dermaplaning**

 \_\_\_Normal side effects (redness, sensitivity to the sun ,windburn feel) abnormal effects

(prolonged redness, swelling, itchiness, cuts ,scabs)

**For BB glow**

\_\_\_Normal side effects (redness,sensitivity to the sun, windburn feel) abnormal side effects (prolonged redness, itching, swelling ,allergic reaction,scaring,scabs)

\_\_ I understand that I must inform my technician about changes in my general medical condition, medication I take and recent sun exposure (including tanning beds or tanning creams) prior to each treatment as this could affect my treatment. I understand the technician will determine the treatment settings depending on certain criteria including my medical history to attempt to treat me with minimal damage to the skin.

\_\_I understand if any of the following are present, I should NOT be treated: latent or active skin conditions such as eczema, psoriasis, uncontrolled diabetes, epilepsy, Rosacea, blood clotting problems ,Scleroderma, cardiovascular disease, cardio abnormalities, immunosuppression, porphyria, hemophilia, dark large moles, dermatitis, skin tumors/cancer, hypo pigmentation, history of keloids ,excessive sunburn, Herpes (cold sores) unless treated with a antiviral skin medication prior and after the treatment

\_\_ Please initial none of these conditions above exist.

\_\_ I understand that if I am under radiation, chemotherapy or taking Accutane or any generic equivalent, skin treatments will be postponed a minimum of 6 months. \_\_ I understand that any scars or wounds must be 6 months or older.

\_\_ I informed my technician about neuromodulators ( Botox) or fillers (Juvederm, Restylane, Perlane) injected in my face as this might be a contraindication. You must have a minimum of 3 weeks prior before micro-needling or Chemical peels can be performed.

\_\_ I am not currently using chemotherapy, radiation, treatments or using anti-cancer drugs at this time.

\_\_I am not pregnant at this time and I will inform Body Beautiful technician as soon as I know I am pregnant or in doubt to be pregnant. I understand that in the event I become pregnant, my treatments will be suspended and will resume after delivery.

\_ I give permission for my photographs to be used to help document my treatment course. Complete confidentiality will be maintained.

\_\_ I received a copy of the Pre and Post treatment instructions and I agree to follow these instructions carefully. I understand that compliance with recommended pre and post procedure guidelines are crucial for healing, prevention, of scaring, side effects, and complications.

\_\_ I certify that I am a competent adult at least 18 years of age. If I am a minor under 18 years of age, I understand that the consent of my parent or legal guardian will also be required before the treatment.

\_\_ I understand that this is treatment that requires 1 week to heal properly and several weeks to show the skin improvement and that I may need multiple treatments to achieve my best results.

\_ I understand that a good home regimen, specific cosmeceuticals, sunscreen and adherence to all pre and post instructions are vital to ensure my best results.

\_I understand that use of tanning beds and or sun exposure without a sunblock with spf 30 or higher between peel will nullify the results achieved and can cause severe burns .

Clients’ signature that all above has been read and is correct:

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/ Guardian (if under 18)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_