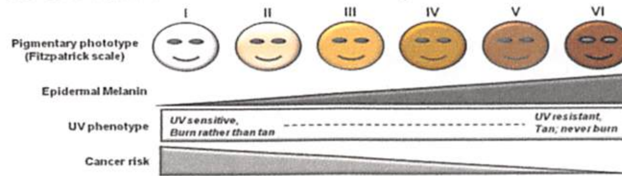
Strawberry & Cream Consent Form

Name:	Date:

Please circle the number of the one that represents your skin type the most



MEDICAL HISTORY: Please check all that apply (if any)

Under age 18	No / Yes	
Cancer (1 yr remission required)	No / Yes	
Currently pregnant / breastfeeding	No / Yes	
Pacemakers defibrillators	No / Yes	
Epilepsy	No / Yes	
Hyper/hypo pigmentation	No / Yes	
Photosensivity	No / Yes	
Autoimmune disease	No / Yes	
Any form of infection, fever or disease	No / Yes	
Keloid scarring	No / Yes	
Bell's palsy	No / Yes	
Severe or cystic acne in treated area	No / Yes	
Any condition where your doctor wants you to avoid laser treatments?	No / Yes	

Lifestyle questions – In the last 6 – 12 months, have you had any of the following?

Plastic surgery (need to be 3 mo post)	No / Yes	

Botox (need to be 2wks post)	No / Yes	
Dermal fillers (need to be 2wks post)	No / Yes	
Semi-permanent make up (may darken)	No / Yes	
Any facial laser treatments	No / Yes	
Any facial ultrasound treatments	No / Yes	
Metal implants or fillings	No / Yes	

PHOTOGRAPHY

× I consent to taking before and after photographs and authorize their ANONYMOUS use for the purpose of medical audit, education, and/or promotion.
Initial Here:

ACKNOWLEDGEMENT

I understand that there are no guarantees to the results of this treatment. I understand to achieve maximum results, I may require additional treatments

Initial Here: ____

I have been informed and understand that temporary hyper-pigmentation/hypo-pigmentation on rare occasion may occur as a result of treatment

Initial Here: ____

I am aware that small temporary blisters may occur at laser diode sites. This is more common with darker skin or people with photosensitivity.

Initial Here: ____

I understand that there is a 24 hour cancellation policy for all appointments. Any no show or late cancellation/reschedule will be counted against my pre-paid sessions.

Initial Here: ____

I also confirm that the answers to the questionnaire are true and correct to the best of my knowledge. I also confirm the staff explained the treatment(s) and answered my questions.

Client Signature Print Name Date