L. Zen Skincare & Health Studio

Glowing on the inside promotes glowing skin on the outside

First Name:	Last Name:
Date of Birth: / /	
Address:	
City:	State: Zip:
Preferred Contact Number:	
Emergency Contact:	Phone:
Referred By:	
1. What is the reason for your visit today?_____	
2. Are you under the care of a physician including dermatologist?	
3. Are you pregnant? _____ Are you planning to become pregnant?_____	
4. Do you smoke?_____	
5. Please circle the one that best describes your daily stress level? High Medium Low	
6. Do you have metal in your body? dental implants, pins, plates, stents, etc. Be specific -	
7. Do you have allergies?	
8. Please list ALL Medications -_____ _____	
9. Do you use any exfoliants? Retin-A, Tretinoic acid, glycolic acid, scrubs, vitamin A derivatives Please specify _____	
10. Do you have or have you had the following: Please circle all that apply:	

Heart Problems	High Blood Pressure	Heart Stent	Mitral Valve Prolapse
Pace Maker	Epilepsy	Fibromyalgia	Lupus
Hepatitis B or C	Immune Disorder	Kidney Disorder	Diabetes
Rosacea	Acne	Skin Cancer	Herpes Zoster (shingles)
Cosmetic Surgery	Botox	Cosmetic Fillers	Asthma
Keloid	Cancer	Sinus Concerns	Fever Blisters

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Instructions -

- **Do not** wear contact lenses during treatment sessions - they may be placed back in after treatment
- **Do not** use glycolic, AHA's, or any retinol products 48-72 hours before or after treatment
- You must not be currently taking Accutane. No Accutane use for at least 8 months to 1 year
- No suntan beds for 2 weeks post treatment (recommend self tanners for a healthy lifestyle change)
- Apply SOL defense SPF 30 physical sunscreen after treatment and any time skin during sun exposure

Initial Required -

___ I have been thoroughly informed by professional therapist _____ of any complications to recommended procedure _____ and I understand there are no guarantees to procedures given by _____.

___ I am committed to following post treatment care given to me by professional therapist _____ to ensure the best possible result.

___ I have given all medical information to the best of my knowledge to _____ to prevent any contraindication to procedures.

Yes or No - I have had history of cold sores, fever blisters and or shingles.

Yes or No - I am using (Retin-A, Tretinoic acid, Differin, glycolic acid, Accutane (isotretinoin) or other vitamin A derivative topical creams and/or ointments.

___ I have not used any performance agents within the last 5-7 days, knowing that this is a contra indicator for having procedures performed.

___ I am committed to avoiding the sun and/or tanning facilities for the recommended time suggested by professional therapist _____.

Client Signature_____ Date _____

Professional Signature _____ Date _____