CHEMICAL PEEL CONSULTATION FORM

FULL NAME:

ADDRESS:

CITY:

STATE:

ZIP CODE:

DATE OF BIRTH:

PHONE:

EMAIL:

EMERGENCY CONTACT NAME:

PHONE NUMBER:

CONSENT SIGNED: ◯ YES ◯ NO

PREVIOUS CHEMICAL PEEL TREATMENT: ◯ YES **DATE:** _____ ◯ NO

ARE YOU CURRENTLY TAKING ANY MEDICATIONS:

◯ YES _____ ◯ NO

WHAT IS YOUR DAILY SKIN CARE REGIMEN?

_____

ALLERGIES? IF YES, PLEASE LIST: ◯ YES ◯ NO

_____

DO YOU PRESENTLY HAVE OR PREVIOUSLY HAD ANY OF THE FOLLOWING:

◯ YES ◯ NO **PREGNANT OR LACTATING**
◯ YES ◯ NO **CONTACT LENSES**
◯ YES ◯ NO **PERMANENT MAKEUP**
◯ YES ◯ NO **CURRENTLY SUNBURNT**
◯ YES ◯ NO **FREQUENT USE OF TANNING BED**
◯ YES ◯ NO **USE OF TOPICAL MEDICATIONS**
◯ YES ◯ NO **RECENT FACIAL SURGERY**
◯ YES ◯ NO **LASER RESURFACING**
◯ YES ◯ NO **AUTOIMMUNE DISORDER**

◯ YES ◯ NO **CANCER**
◯ YES ◯ NO **ACCUTANE OR ACNE TREATMENT**
◯ YES ◯ NO **CHEMOTHERAPY/ RADIATION**
◯ YES ◯ NO **TUMORS/ GROWTHS/ CYSTS**
◯ YES ◯ NO **TAKING BLOOD THINNERS SUCH AS: ASPIRINM IBUPROFEN, ALCOHOL, ETC.**
◯ YES ◯ NO **ALCOHOL-BASED PRODUCTS SENSITIVITY**
◯ YES ◯ NO **DO YOU USE SKIN CARE PRODUCTS CONTAINING RETIN-A, GLYCOLIC ACID OR ALPHA HYDROXYL?**

TYPE OF SKIN ◯ SENSITIVE ◯ RESILIENT ◯ NOT SURE

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☐ I understand that there are some risks with any procedure and I agree to assume those risks. I understand there may be some degree of discomfort including: stinging, pin-prickling sensation, heat, or tightness. I understand that although complications are very rare, sometimes they may occur and that prompt treatment is necessary. In the event of any complications, I will immediately contact the doctor/ clinician who performed the treatment.

☐ Prior to receiving the treatment, I have been candid in revealing any condition that may have bearing on this procedure, such as: pregnancy, recent facial surgery, allergies, tendency to cold sores/fever blisters, use of Retin-A, Acutane, Diffferin, Tazorac, or Avage.

☐ I understand this treatment is a cosmetic treatment and that no medical claims are expressed or implied. I understand that to achieve maximum results, I may need several treatments.

☐ I understand that results may not be seen in a single treatment. I am aware that the results achieved by this treatment may vary from person to person and that there are no guarantees as to the results of this treatment, due to many variables, such as: age, condition of skin, sun damage, smoking, climate, etc. I understand I may or may not actually peel, that each case is individual.

☐ I agree to refrain from using tanning booths while I am undergoing treatment, and during the 14 days following the end of treatment. I understand that extended direct sun exposure is prohibited while I am underging treatment, and the daily use of sunscreen protection with a minimum of SPF 30 is mandatory.

☐ I have not had any other chemical pel of any kind within 14 days of the treatment. I understand I cannot have another within 14 days of this treatment, whether it is performed at this location or any other location.

☐ I release my technician or salon/spa (_____) from all liability associated with this procedure. I will not hold the technician or business performing this service on me responsible in any way for any damages or issues that may arise as a result of having the chemical peel procedure performed on me. I represent that I am over the age of 18 years. If below 18 years of age a parent or guardian must also sign this form. Guardian Signature

☐ By signing below, I verify that I have read and understand the above statements and agree to them. I further agree to follow all post-peel care instructions as I am directed.

Client Signature: Date: