Current Electrology
21515 Chagrin Boulevard ~ Suite 204
Beachwood, OH 44122
Currentelectrology.com
216.773.2306

Today's Date:_____

Preferred Name:_____

Legal Name:_____ Date of Birth: _____ Age:_____
Street Address:_____
City: _____ State/Country: _____ Zip/Postal Code:_____
HM. Phone:_____ Cell Phone: _____ Email: _____
Occupation:_____ Referred by:_____

Check the areas you wish to have treated:

Facial/Head Areas

☐ * Lips	☐ * Neck	☐ * Eyebrows	☐ * Breasts/Chest	☐ * Abdomen	☐ * Legs/Thighs	☐ * Shoulders
☐ * Nose	☐ * Sideburns	☐ * Ears	☐ * Back/Spine	☐ * Buttocks	☐ * Fingers	☐ * Underarms
☐ * Chin	☐ * Cheeks	☐ * Hairline	☐ * Arms	☐ * Bikini Line	☐ * Toes	☐ *_____

In above areas noted with asterisk (*), explain if onset was sudden or gradual, and over what period of time:_____
Family members with similar hair growth patterns:_____
Previous electrology treatments: ☐ Yes ☐ No Date of first treatment: _____ Date of last treatment: _____
Areas treated and treatment schedule of each area:_____
Aftercare used:_____ Reason for discontinuing treatment:_____

Temporary hair Removal Methods Previously or Currently Used:

METHOD		FREQUENCY	LAST USED
Tweezing	☐ Yes ☐ No	_____	_____
If tweezing, give the approximate number of hairs removed in each area in one week: _____			
Threading	☐ Yes ☐ No	_____	_____
Waxing	☐ Yes ☐ No	_____	_____
Depilatory (example -Nair)	☐ Yes ☐ No	_____	_____
Shaving	☐ Yes ☐ No	_____	_____
Laser	☐ Yes ☐ No	_____	_____
Bleaching	☐ Yes ☐ No	_____	_____
Other: _____	☐ Yes ☐ No	_____	_____

Check, if in the past year, you have had any signs on your skin of:

☐ swelling ☐ itching ☐ dryness ☐ oiliness ☐ pigment changes ☐ sensitivity

Check, if you have had any of the following lesions on your skin:

☐ acne ☐ eczema ☐ dermatitis ☐ psoriasis ☐ petechiae (red point) ☐ lipomas (soft lump) ☐ keloids ☐ scars
☐ cancer ☐ boils ☐ blisters ☐ hives ☐ herpes ☐ warts ☐ moles ☐ rashes

Check, if you have had allergies to:

☐ medicines ☐ cosmetics ☐ plants ☐ benzocaine ☐ metals ☐ latex
☐ soaps ☐ foods ☐ sun ☐ aloe ☐ other_____

Check the following, if you ever had, or have been treated for the following conditions:

☐ Bleeding problems/Hemophilia	☐ Sensory problems	☐ Epilepsy	☐ High blood pressure
☐ Circulatory problems	☐ Metal in the body	☐ Diabetes	☐ Herpes (location)_____
☐ Asthma/Breathing problem	☐ Chest pains	☐ Cancer	☐ Sexually Transmitted Diseases
☐ Anxiety	☐ Heart disease	☐ Chemo/radiation	☐ Hepatitis (type) _____
☐ Pacemaker	☐ HIV/AIDS	☐ Tuberculosis	☐ High or Low blood Sugar

Comments on above if checked:_____

_____

Currently being treated by a physician or other health-care provider: ☐ Yes ☐ No Explain:_____

Current medications (oral, injection, topical, including **VITAMINS**):_____

_____

Ever had problems with your skin healing:_____ Explain:_____

Use facial scrubs or abrasive sponges:_____ Areas/Frequency:_____

Ever use Retin A Or ACCUTANE: ☐ Yes ☐ No Dates/Explain: _____

Ever use artificial tanning: ☐ Yes ☐ No Areas/Frequency:_____

Have you ever taken or been affected by any of the following:

☐ Steroids (oral or inhaled)	☐ History of irregular periods	☐ Pubic/underarm Hair by age 6
☐ Gradual Hair growth(months)	☐ Rapid Hair growth (WEEKS)	☐ Coarse Hair growth (pubic type on abdomen)
☐ Dilantin	☐ Thorazine	☐ Neurontin/Topamax

Do you have temp./perm. Implants (i.e., IUD, dental, orthopedic): ☐ Yes ☐ No _____

Do you wear contacts: ☐ Yes ☐ No Is your stress level high: ☐ Yes ☐ No Nicotine/Tobacco Use: ☐ Yes ☐ No

Current Height: _____Ft. _____ Inches Weight: _____ (Please note: Our treatment table has a max load of 300 lbs.)

FEMALE CLIENTS:

Frequency of gyn. Examinations:_____ Date of last exam:_____

Are you presently pregnant, or attempting to become pregnant: ☐ Yes ☐ No

Menstrual cycle every: _____ days, pregnancies: _____ deliveries:_____ miscarriages: _____

If post-menopausal, give date of last menses: _____

Was menstrual cycle regular: ☐ Yes ☐ No Increase/decrease of hair:_____

Hysterectomy: ☐ Yes ☐ No Date: _____ Ovaries removed: ☐ Yes ☐ No Increase/decrease of hair:_____

Estrogen/progesterone therapy: ☐ Yes ☐ No Dates/explain: _____ Increase/decrease of hair:_____

Ever take birth control pills: ☐ Yes ☐ No Dates/explain:_____

Ever had an ovarian cyst or cystic ovaries: _____ Date/explain:_____

Is thyroid function normal: _____ Explain:_____

Recent changes in weight or voice: _____ Explain:_____

Ever inform your physician/gyn. of your hair growth: _____ Response: _____

Ever had a hormone level test: _____ Date/results: _____

I agree that all information contributed by me is accurate to the best of my knowledge, and that the present condition of the areas to be treated is as stated on this record, I understand that repeated treatments are necessary. It is my responsibility to update the medical practitioner of any changes.

Client's Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____

CLIENT INFORMED CONSENT FOR THE PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

The risks include but are not limited to:

(You can count on the following to some degree or another.)

Redness

The treated area will have redness immediately after, which will last anywhere from half an hour to well into the next day. Common treatments include witch hazel to cleanse and cold aloe to soothe the area just after treatment.

Swelling

This may be overall puffiness on your face, and some raised bumps or welts immediately after. Usually these welts look like an insect bite here and there, but sensitive clients will see a more pronounced amount. Swelling may subside immediately following treatment, last several hours or up to a week or two depending on the amount of treatment done in a single session. Ice is used to reduce swelling, although ice often increases the redness. This is why it's good to schedule your treatment so that the redness and swelling won't be noticeable to others.

Tiny blisters (scabs, crusts, petechiae, or eschars)

Tiny raised white blisters that look like acne. These sometimes scab over, and most people aren't going to mention it to you. It's best to cleanse the area and leave them alone to minimize scarring. DO NOT REMOVE THESE.

Ingrown hairs

Occasionally treated weakened hairs may not push through the skin and remain below the skin's surface. There is a chance an ingrown hair may become infected or cause inflammation. Getting ingrown hairs out must be done very carefully.

PLEASE DO NOT try to "dig them out" this can cause scarring. However, prevention is best.

Breakouts/folliculitis (inflammation of follicles)

This is best treated by doing as little to your skin as possible between sessions. Use the mildest cleanser and gentlest moisturizer, and avoid shaving if possible. Avoid drying products like benzoyl peroxide which may make the acne worse.

Dryness/flaking/itching

This can worsened by the use of hormones, which may also be the actual cause of dryness. The best treatment is aloe gel for a day after treatment, followed by a hydrating moisturizer with SPF (sunscreen).

Skin discoloration

Although rare, people prone to scarring may experience hyperpigmentation (darkening). Much rarer is hypopigmentation (skin lightening). A history of this should be carefully considered prior to choosing this form of treatment.

Permanent scarring and pitting

Usually seen in people prone to forming thick scars but the chance exists in all clients. The scars may be noticeable quickly resembling depressions in the skin. Dark-skinned people may develop dark or white areas around the treated hairs.

"Tombstones"

Hardened debris left in a treated follicle, resembling blackheads. Eventually, the follicle will push this out with natural action.

Bleeding/Bruising

Small amounts of bleeding and/or tiny bruises when the probe is inserted and punctures a capillary.

Signed _____ Date_____

Current Electrology's policies are presented and provided in the best quality and tradition of excellence for our established and future clientele.
Thank you for viewing and supporting our policies criteria.

Photography

Clinical photography may be taken during the initial consultation and at intervals and is necessary for treatment. Photographs of cosmetic and/or medical removal of hair are appropriate for professional education and/or marketing purposes. Once taken, clinical photographs become a permanent part of the health record. Clinical photography can be accomplished through a variety of multimedia technology (film, digital, video, etc.) at the discretion of the practitioner. I understand that although efforts will be used to protect the identity of the subject of any photograph, it is possible that the subject may be identified. I understand that all images are the property of Current Electrology and may be used for educational and/or marketing purposes.

STRICT AND ENFORCED 24 HOUR CANCELLATION POLICY

Please understand that when you forget or cancel your appointment without giving enough notice, we miss the opportunity to fill that appointment, and clients on our waiting list miss the opportunity to receive services. Since the services are reserved for you personally, a Cancellation fee will apply.

- **"NO SHOWS" and less than 24 hour notice cancelations will be charged 100% of the reserved service amount and will be required to prepay for future appointments.**
- **Appointments made within the 24 hour period and need to cancel, the client then must cancel within 4 hours of appointment time or will result in a charge equal to 50% of the reserved service amount.**
- **Any multiple hours or multiple services must be prepaid with a credit card. Multiple services or combos not cancelled 24hours in advance will be charged 100% of the reserved service amount.**
- **Any available prepaid sessions or vouchers can and will be used as payment for less than 24 hour cancellations.**

I have read and understand this authorization form. I hereby agree to abide by the policies stated above. I agree to follow the directions for care as outlined by my Cosmetic Therapist including my appointment schedule as reasonably possible. In return for services to be provided by Current Electrology I promise to pay for services rendered by Current Electrology to me or for my benefit and abide by the cancelation policy. I authorize and release Current Electrology and its employees and agents to take photographs, and/or other images of me. No compensation has been offered or implied. Since electrolysis treats unwanted hair as a symptom of internal processes Current Electrology cannot guarantee any specific result(s) from treatment. While routinely performed without incident, there may be risks associated with this procedure and I have been informed of these risks and I am aware of other available options. I release Current Electrology, and its professionals from any liability for any accident or injury that is not directly caused by the negligence of Current Electrology or its employees. I give consent to and authorize Current Electrology for the specific purposes of providing treatment to me, and for general administrative operations of the practice.

Signed _____ Date _____
Client

MINOR INFORMED CONSENT

I hereby give permission (and until further notice) to Current Electrology to provide my minor child/person under my guardianship with electrology services. I understand that I am financially responsible for the minor, and that all statements contained in this consent apply equally to myself and to the minor. I also understand that all appointments must be made by me for subsequent care.

Signed _____ Date _____
Client

Signed _____ Date _____
Parent/Guardian

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