Aries Eleven
ELECTROLYSIS STUDIO

ELECTROLYSIS CLIENT HEALTH HISTORY

DATE: _____

PERSONAL INFORMATION

Client Name (Last/First): _____
Client DOB (MM/DD/YY): _____
Client Telephone (Preferred No.): _____
Client Address 1 (Street): _____
Client Address 2 (City/State/Zip): _____
Client Email Address: _____
Client Emergency POC (Name/Telephone): _____
Reference (Name): _____
Reference (Other, Ex., Internet, Advertisement, Social Media): _____

MEDICAL INFORMATION

Client General Physician (Name/Telephone):
Client Pre-Existing Skin Conditions (Check All that Apply):
___ Skin Disease (Psoriasis/Eczema/Herpes Simplex)
___ Sebaceous Disease (Acne/Comedone/Milia)
___ Pigmentation (Tan/Freckles/Chloasma)
___ Hypertrophies (Callus/Keloid/Wart/Mole/Melanoma)
___ Other _____

Client Pre-Existing Medical Conditions (Check All that Apply):
___ Diabetes
___ Hormone Imbalance
___ Permanent Makeup/Tattoos
___ Polycystic Ovary Syndrome (PCOS)
___ Bleeding/Clotting Disorder
___ Active Infection(s)
___ HIV/AIDS
___ Oral Steroids
___ Thyroid Imbalance
___ Pregnant/Lactating
___ Venereal Disease
___ Pacemaker/Metal in Body
___ Other _____

Client Surgical History: _____
Client Medication(s) (Current-Including Aspirin or OTC): _____
Client Allergies (Check All that Apply):
___ Cosmetics
___ Medicines
___ Topical Anesthetics
___ Stainless Steel
___ Other _____

ELECTROLYSIS INFORMATION

Has the Client Received Electrolysis in the Past?: Yes/No Laser? Yes/No
Areas Treated: _____
Current Temporary Method(s) of Hair Removal:_____

ARIES ELEVEN ELECTROLYSIS STUDIO
7009 PEBBLE LANE E
SPOTSYLVANIA, VA 22553

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ELECTROLYSIS CLIENT CONSENT FORM

ELECTROLYSIS TREATMENTS

I Understand that My Health History is Important to the Electrologist in Order to Provide Me with a Safe and Effective Treatment Regime. I Acknowledge All Information Submitted by Me, to Be Accurate and True. I Agree to Update My Client Health History Assessment When Changes Take Place. I Understand a Series of Treatments is Necessary to Achieve Permanent Hair Removal Results, Regardless of Previous Temporary Treatment Methods. I Understand that the Frequency and Longevity of Treatments is Determined Solely by My Body's Natural Hair Growth and Therefore Not Predetermined. I Have Been Advised in Detail of the Process of Electrolysis, Post-Treatment Aftercare, and Potential Side Effects. I Agree that I am Voluntarily Requesting Electrolysis Treatment and Agree to Accept All Risks Associated with Receiving Treatment and to Follow All Aftercare Healing Instructions. I Will Notify Aries Eleven Electrolysis Studio of Any Questions or Concerns.

Patient Signature: _____
Date: _____
Parent/Guardian Signature: _____
Date: _____

Carrie Tarquinio Heflin
Owner/Professional Electrologist
Aries Eleven Electrolysis Studio

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