AFTERGLOW Laser Spa

649 Colborne St. London, ON N6A 3Z2 Inside Whole Health Naturopathic Clinic 519-697-9129

Intense Pulsed Light Treatments

Medical Intake Form

Client Information:

Full Name: _____ Sex: Female __ Male __
Birth Date: _____ Today's Date : _____
Cell: _____ Home Phone: _____
Email: _____
Address:_____
City: _____ Postal Code: _____
Emergency Contact: _____ Phone: _____

Thank you for choosing Afterglow Laser Spa

To whom may we give thanks for your visit to our spa? (ex: web browser, kijiji, facebook, word of mouth, friend, etc.)

What did you search for, & what made you choose us?

What other services are you interested in learning about? (ex: 3D Microblading, age spot reduction, spider vein treatments, etc.)

Referral Rewards:

If you know anyone who could benefit from any of our services, please print your name on our *Referral Reward Cards* and pass it out to as many people as you like. ***For new clients, it has a value of $25, applicable to any regular priced service.*** **Plus, if they use it, we will give you a $25 credit as well.** There is no limit to referral credits, so spread the word about Afterglow Laser Spa, and you can stock up your credits for something good!

Medical History:

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Have you been exposed to sun, used self-tanners, or tanning beds in the last 4-6 weeks in the area you wish to treat? Yes __ No __

Have you waxed, sugared, tweezed or used any other form of epilation in the last 6 weeks? Y__ N __ (*for hair removal procedures only*)

Do you use products containing Retin A, Vitamin A, Hydroxy, Glycolic acid, or Salicylic acid? Yes __ No __ If yes, please list:

Have you had any other laser treatments done in the treatment area within the last 4-6 weeks? Yes __ No __ If yes, please list:

Have you taken Accutane in the last 6 months? Yes __ No __

Have you used or taken any substance, medication, natural supplements or topical creams that cause sun sensitivity, (Photosensitivity)? Please read all labels prior to treatment to ensure your safety. Yes __ No __ If Yes, please list:

Do you have any allergies? Yes __ No __ (Ex: Food, Meds, Latex, Topical Anesthetic)
If Yes, please list:

Do you have any body or cosmetic tattoos? Yes __ No __ If Yes, please list:

Is there any chance you are pregnant? Yes __ No __ (*for women only*)

Are you taking any anticoagulants? Yes __ No __ If Yes, Please List:

Are you diabetic? Yes __ No __

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Have you ever tested positive for any blood borne diseases like HIV or Hepatitis? Yes __ No __

Have you ever had a cold sore? Y __ N __

Do you have a history of herpes virus 1 or 2? Y __ N __

**If yes, treatments can still be performed as long as there is not an active breakout. Please be aware that there is a risk that if you already have the herpes virus, 1 or 2, or cold sores, in the desired treatment area, IPL services can activate a break out. You can ask your doctor about Valtrex. It is possible that your doctor may recommend taking it for full week prior to your service to help prevent a break out after your IPL service. We cannot prescribe Valtrex, or guarantee that you will not have a break out even if Valtrex is taken.

**If you checked yes above, please initial below to indicate that you understand the risks involved, that you still wish to proceed with treatments, and will give us 24 notice should an active breakout occur before your scheduled appointment(s). You further understand that should you fail to give 24 hours notice, and the treatment cannot be performed, it will result in the loss of that session (where packages have been pre-paid or deposits have been made), and no refund will be given. Initial here: _____

Do you have any serious medical conditions such as, active cancer, heart conditions, or active infections? Yes __ No __ If yes, please list:

Are you presently taking any medications, including but not limited to immunosuppressants, anti-inflammatories, steroids, blood thinners? Yes __ No __ If yes, please list:

Do you bruise or swell easily? Yes __ No __ If yes, circle to indicate.

Do you have a history of pronounced keloid scarring? Yes __ No __

Have you ever had a seizure, or been diagnosed with Epilepsy? Yes __ No __

Are you able to take over-the-counter antihistamines, i.e. Benadryl? Yes __ No __

Are you able to take over-the-counter pain meds, i.e. Tylenol, Advil? Yes __ No __

Are you able to use topical ointments, i.e. Polysporin, Neosporin? Yes __ No __

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Do you exercise heavily, or take part in activities that raise your body temperature abnormally, on a regular basis? (ie: hot baths, saunas, work environment, steam rooms) Yes___ No ___

Other Health Concerns:

If you have any other health conditions, or concerns not listed above, that you feel could be a important to discuss, please list them below. If you are uncertain, we advise that you consult your doctor prior to any treatments to see if IPL services are safe for you. Afterglow Laser Spa holds the right to refuse treatment, and may require for a doctor's note of approval to have IPL services done, prior to treatments for those with certain health conditions.

I, the undersigned,(Print full name) _____, have answered the above questions fully, and truthfully, and will advise Afterglow Laser Spa if any changes occur, prior to any future procedures.

_____

Client Signature

_____

Date: (dd/mm/yyyy)

_____

Technician’s Signature