HEALTH HISTORY ASSESSMENT

Name _____
Address _____
E-mail _____
Today's Date _____ Home Phone _____
Referred by _____ Work Phone _____
Date of Birth/Age _____ Emergency or Cell Phone _____
Instructions for Calling _____

CIRCLE AREAS TO BE TREATED:

Front Hairline	Brows	**Upper/Lower Lip**
Cheeks/Sideburns	**Chin/Under Chin**	Throat/Jawline
Ears	Nape of Neck	Back
Chest/Breasts	Shoulders/Upper Arms	Forearms
Underarms	Hands/Fingers	**Upper/Lower Abdomen**
Upper/Inner Thighs	Lower Legs	Feet/Toes

Other Areas _____

HORMONE-RELATED QUESTIONS for females with hair growth on areas above in **bold.**

What age did hair growth begin? _____ Regular menstrual cycle every _____ days.

Circle all that apply:

Fertility problems	Hormone/Endocrine disorder	Scalp hair loss
Weight gain/loss	Family history of similar hair growth	Irregular menses
Acne	Hysterectomy or Menopause	Eating disorder

Other hormone problems or explanation of above: _____
What do you believe caused your hair growth? _____
Electrologist's notes: _____

PREVIOUS METHODS OF HAIR REMOVAL

Circle all methods that you have used and add date when last used:

Shaving _____	Waxing/Sugaring/Threading _____	Bleaching _____
Cutting/Clipping _____	Tweezer/Patch/Swab _____	Laser _____
Depilatories _____	Tweezing _____	Light-Based _____
No methods used _____	Other methods (explain) _____	
Electrolysis _____	Name of previous electrologist: _____	

How long did you use these methods of hair removal? _____weeks _____months _____years

How often do you remove your hair? DAILY WEEKLY MONTHLY INFREQUENTLY

Skin reactions to previous hair removal methods: circle all that apply

Redness	Pimples	Infections	Pigmentation
Ingrown hair	Swelling	No skin reaction	

Other _____

Permission to photograph area to be treated: YES NO *(please initial)* _____

Electrologist notes: _____

GENERAL HEALTH QUESTIONS

Current medications _____

Reason for medications _____

Past medications _____

Reason for medications _____

Circle all conditions, past and present that apply:

Acne	Allergy to Metal	Hepatitis	Healing Problems
Allergy to Aspirin	Cold Sores	Herpes	Metal Implants
Allergy to Latex	Diabetes	HIV	Body Piercings
Cardiovascular disease	High Blood Pressure		Pacemaker
Breathing Problems	Pigment Problems	TB	Warts
Cancer	Skin Tags	Keloids	Current Pregnancy

Other conditions or allergies: _____

Date of last complete physical: _____

Electrologist notes: _____

_____

ACKNOWLEDGMENT OF INFORMATION *(please initial each paragraph)*

I understand health history information is important to the Electrologist in order to provide me with safe and effective electrology treatments. I acknowledge all information given by me is accurate to the best of my knowledge and I agree to update my health history assessment whenever there are changes._____

I understand that a series of treatments is necessary to achieve permanent hair removal based on my previous temporary methods of hair removal, the science of electrology, and my individual physiological factors. _____

I have been advised of the post-treatment healing process; the possible risks related to treatment, I agree to follow all aftercare instructions and to notify the Electrologist of any concerns or difficulty in healing. _____

Patient/client signature Parent/guardian signature for minor Date

Electrology Notes on Skin & Hair Condition in areas to be treated *(Patient Initial)* _____

Hair Type: vellus accelerated vellus medium terminal deep terminal

Hair Density: 0-15 per sq cm 16-25 per sq cm 26-35 per sq cm 36-50 per sq cm >50

Skin Type: I II III IV V dry combination oily dehydrated moist

Skin Pigmentation: PIH Vitiligo Chloasma Freckles

Other Observations: _____

Skin Texture: fine medium coarse

Skin Irregularities: Superficial Acne Deep Acne Moles Keratosis

Other Observation: _____

_____

FLaSH Electrolysis Acknowledgement Cancellation Policies

FLaSH Electrology offers to the public prices on permanent hair removal on a "by appointment" basis. To accommodate clients it is asked that you be aware of cancellation and late arrival policies.

CANCELLATION:

Forty-eight (48) hours' notice ***is required to avoid a full price cancellation fee***. Please call FLaSH to cancel, reschedule or adjust your length of treatment time. Your payment is based on your booked time. Responding to FLaSH's text/phone reminders is not an opportunity to cancel. The service is just a reminder. Please understand It is difficult, if not impossible, to schedule another client because your appointment time has been set-aside for **YOU.** The amount of time scheduled AND the specific date is geared to your particular needs and arranging for another client to fill your space is impractical. In addition, finding a client last minute with hair growth in an ideal stage requiring the same amount of treatment time is unrealistic.

Late arrivals will result in shortened treatment time. The intention of this policy is to better serve clients and to not inconvenience those who are on time.

Pregnancy - Although no studies have been conducted to determine the safety of electrolysis during pregnancy, it is FLaSH's policy that all pregnant women must have a letter of authorization from their physician. No galvanic electrolysis will be performed nor will work be done on or near the breast or abdomen.

I HAVE READ THE ABOVE POLICIES AND UNDERSTAND AND AGREE TO BE BOUND BY IT. I authorize FLaSH Electrolysis to bill my credit card for less than 48 HOURS NOTICE to cancel or reschedule.

Credit Card_____ Exp Date_____ Security Code_____

_____ _____ _____

Client's Signature Client's Printed Name Date

(Client – please take a photo of this document for your records). Thank you