

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 of Policies

FLaSH Electrology offers 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. Appointments are reserved exclusively for you. Please doublecheck your calendar prior to booking to ensure your selected appointment time works for you.

As a small, appointment-only business, I kindly ask that you call or text FLaSH at 949-230-1717 to cancel, reschedule or adjust your length of treatment time. This allows the opportunity to offer that time to another client in need of care. Appointment reminder and confirmation text messages are sent as a courtesy *only* and do not alter the **48-hour cancellation policy**. They do not provide the option to cancel or reschedule without proper notice.

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.

No Cell Phones

It is requested that you do not use your cell phone during facial treatment.

Children

Children are not allowed in the treatment room and may wait in the reception area. This policy is both for your child's safety as well as the health and safety of you and the electrologist.

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.

Thank you for respecting my time and supporting my small business. Your understanding allows me to provide dedicated, personalized service to each and every client.

I acknowledge that I have read, understand, and agree to be bound by the above policy.

Client Name: _____

Signature: _____ Date: _____

PLEASE TAKE A PHOTO OF THIS ACKNOWLEDGEMENT FOR YOUR RECORDS