MV Makeup & Skin Care

MICROCURRENT TREATMENT CONSENT FORM

Name: ______________________ Date of Birth: ______________
Address: ______________________ City: ______________
State: __________ Zip: __________
Cell Phone: __________ Home Phone: __________ Email Address: ______________

SKIN TYPE: Review the skin types below, using the Fitzpatrick Scale, and check the one that best describes your skin. This information will be used by your technician to determine the most appropriate way to approach your treatment(s):

________I. Very fair skin; blonde or red hair; light-colored eyes; freckles common
________II. Fair skinned; light hair, light eyes
________III. Very common skin type; fair; eye and hair color vary
________IV. Mediterranean Caucasian skin; medium to heavy pigmentation
________V. Mideastern skin; rarely sun sensitive
________VI. Black skin; rarely sun sensitive

Are you of Asian heritage (Class V) and/or have a history of keloid scarring? Yes or No (Circle One)

Please list the products you use regularly:

Facial Cleanser ______________ Moisturizer ______________ Toner ______________
Serum ______________ Scrubs ______________ Sunscreen ______________
Retinol ______________ Glycolic Acid ______________ Enzymes ______________
Peptides or Growth Factors __________

Cosmetic History

How would you describe your skin? Normal _____ Combination _____ Oily ____ Dry _____
When were you last exposed to the sun (including tanning beds)? ______________
Do you use sunless tanning products? Yes _______ No ______ If yes, when was it last applied? ______________
Do you have hyperpigmentation (darkening of the skin) or hypopigmentation (lightening of the skin) or marks after physical trauma? Yes ___ No _____
If yes, please describe ______________

____

Have you had chemical peel treatments in the past? Yes ____ No ____ If yes, when? ______________
Describe your experience ______________

____

Are you currently using, or have you used in the past year, any of the following? Yes (circle one) ___ No ____

Isotretinoin (Accutane)	Tretinoin (Retinoic Acid)	Acyclovir	Glycolic Acid	Salicylic Acid
Adapalene (Differin)	Hydroquinone	Azelaic Acid	Lactic Acid	Spironolactone

If yes, when? ____________

Are you using any topical creams, lotions, or oral antibiotics for acne, skin cancer, antiaging or hyperpigmentation? Please List:

____

Have you ever had any of the following injectables or implants?

Botox	Juvederm	Radiesse	Restylane	Perlane	Silicone
Collagen	Sculptra	Dysport	Other: ______________		

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If yes, when? ______________________________ What body area(s)? ______________________________

Have you had any facial cosmetic surgeries/procedures, piercings, metal implants, tattoos, or use of a pacemaker within the past year?
Yes _____ No _____ If yes, when? ______________________________
Have you had any laser resurfacing treatments in the past six weeks? Yes _____ No _____ If yes, when? ______________________________
Have you used any of the following hair removal methods in the past six weeks? Shaving _____ Waxing _____ Electrolysis _______
Tweezing ______ Threading ______ Depilatories _______

Health History
Have you had chemotherapy in the past 6 months? Yes _____ No _____
Do you have any allergies to medications, food, latex, topical products, and/or other substances? ______________________________
____

Do you have any of the following conditions?
Eczema _______ Dermatitis _______ Hormone Imbalance _______ Pregnancy and/or breastfeeding _____ Autoimmune Disease __
Herpes Simplex (cold sore) _______ Diabetes_______

Do you have any other health condition(s) not mentioned here? Yes ____ No _____
If yes, please list ______________________________
Are you currently on birth control? Yes___ No____ If yes, please describe ______________________________
Have you consumed drugs or alcohol in the last 24 hours? Yes___ No___
Please list all vitamins and supplements including herbal remedies you take regularly ______________________________
____
Please list all current medications including aspirin, ibuprofen, blood thinners, etc. you take regularly ______________________________
____

Is there anything else you would like us to know? ______________________________
____

Please be aware of the following information and possible risks. Please initial:
_____ I understand there are certain contraindications that would preclude me from receiving microcurrent treatments, including autoimmune disorders, diabetes, embolism, epilepsy, melanoma, metal implants including plates/pins/screws, open wounds, pacemaker use, phlebitis, pregnancy, thrombosis, and varicose veins.
_____ I understand that the use of Botox®, Juvederm®, Restylane®, and any other injectable must be disclosed prior to treatment.
_____ I understand that microcurrent treatments involve conducting mild electrical currents through the body, and that this brings some inherent risk.
_____ I understand that reactions are rare, but may include nausea, dizziness, weakness, and possible skin reactions including redness and/or other irritations.
_____ I understand that some clients report slight tingling sensations, flashing of the optic nerve, and/or a metallic taste in the mouth during the procedure.
_____ I understand that while the goal of this treatment is to improve the vitality of the skin, no specific guarantees of the result can or have been made.
_____ I understand that it is imperative to my health that I disclose all of the information requested in the Client Profile/Health History.
_____ I have cited all conditions and circumstances regarding my health history, medications being taken, and any past reactions to products or medications.

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_____ I understand that additional conditions could occur or be discovered during the procedure which could affect my ability to tolerate the procedure.

_____ I consent to "before and after" photographs for the purpose of documentation, potential advertising and promotional purposes.

_____ I understand that if I have any concerns, I will address these with my skin care specialist. I give permission to my skin care specialist to perform the microcurrent procedure we have discussed, and will hold him/her and his/her staff armless and nameless from any liability that may result from this treatment. I have accurately answered the questions above, including all known allergies, prescription drugs, conditions, or products I am currently ingesting or using topically. I understand my skin care specialist will take every precaution to minimize or eliminate negative reactions as much as possible. In the event I may have additional questions or concerns regarding my treatment, I will consult the skin care specialist immediately. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read, and fully understand, the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered. I understand the procedure and accept the risks. I do not hold the skin care specialist, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this procedure, which may be affected by the treatment performed today.

_____ I certify that the preceding medical, personal, and skin history statements are true and correct. I am aware that it is my responsibility to inform the esthetician of my current medical or health conditions and to update this history. A current medical history is essential to execute appropriate treatment procedures.

Client's Name (Please print legibly): ______________________________________

Client's Signature: ______________________________________ Date: ______________

Parent/Legal Guardian (If Client Is Under 18): ______________________________________

Parent/Legal Guardian's Signature: ______________________________________ Date: ______________

Practitioner statement: I have personally reviewed the above information with my client or the client's representative.

Practitioner's Name: ______________________________________

Practitioner's Signature: ______________________________________ Date: ______________