



# Beauty On The Spot

## Laser Hair Removal Consultation

### Personal Information

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Work/Mobile Phone: \_\_\_\_\_

City: \_\_\_\_\_ Town: \_\_\_\_\_ Post code: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: F/M: \_\_\_\_\_

GP Name & Address: \_\_\_\_\_

Email: \_\_\_\_\_

### Medical History: Please tick the relevant box.

Bleeding disorder :  bruise easily:  Endocrine / hormone issues  Diabetes:  Lupus:   
Pigmentation disorder:  Pacemaker / defibrillator:  Epilepsy:  Lymphatic/Immune system  
Disorder:  History of cold sores:  Accutane within 6 months:  History of keloid inflammation  
scarring:  History of skin cancer:  Dermatological conditions:  Photo allergic  Steroids Therapy:   
High blood pressure:  History of cancer:  Pacemaker or internal defibrillator:  Any abnormal or  
undiagnosed pigmentation:  Laser resurfacing in treatment area within 3 months:  Are you  
Pregnancy:

Are you currently taking any medications or supplements please specify your condition:

Comments: \_\_\_\_\_

Currently using /used allergies In the last 3months any of the following (Please tick the relevant box)

St John Wort :  Anticoagulants:  Antibiotics :  Gold medication:  Accutane :  Retin A:

Comments : \_\_\_\_\_

Has the area which will be treated ever had any of the following: (Please tick the relevant box).

Chemical peels:  Botox:  Injectable Fillers:  None:  Laser or IPL before:

Your skin: What Products do you use on your skin?

Please indicate how your skin responds to midday summer sun exposure with no sunscreen protection.

- Skin Type 1** Always burns, never tans.
- Skin Type 2** Easily burnt, eventually gets a moderate tan.
- Skin Type 3** Sometimes burns quickly gets a deep tan.
- Skin Type 4** Rarely burns, quickly gets a deep tan.
- Skin Type 5** Very Rarely burns, consistent tan.
- Skin Type 6** Never burns, consistent tan

Do you currently have a real  or a fake tan:

Have you had any sun Exposure or sun beds in the last 4 weeks? Yes  or No

What are your expectations or goals of this treatment?

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Pre-treatment check list to be completed by the operator (Tick to confirm points have been discussed)

How treatment works:  pre post treatment care:  SPF advice:  Typical no of treatments/intervals

Likely clinical outcome:  Sensation during Treatment:  possible side effects:

**Consent:**

The information I have given is correct to the best of my knowledge, and I have not withheld any know medical state or condition. I will inform the IPL/LASER technician before treatment if there has been any change (for example in my medications taken)

I understand that the results from this treatment vary considerably and a small percentage of people will not respond depending on your hair type satisfactory to the treatment.

I understand that multiple treatments are necessary to get the best results as the amount of treatments will vary from client to client.

I understand there is no guarantee of permanent results and maintenance treatment may be necessary.

I understand that I must avoid sun exposure on the treated area for the duration of the treatment for up to 1 month afterwards or a use of high sun protection factor to avoid sun damage. I understand that tanned skin cannot be treated.

I understand that there may be short – term side effects such as reddening, brushing, swelling, mild burning, hypo pigmentation ( lightening of the skin) or hyper pigmentation (darkening of the skin) as well as a rare side effect or scaring and permanent discolouration .

I understand that pigmentation areas caused by damage may initially turn darker .This will be followed by micro –crusting of the lesion, after which will flake away without leaving damage or pigmentation.

I understand that I must wear protective goggles which will protect my eyes any from possible damage due to the light.

I have read and understood all the information and my questions have been answered satisfactory before signing the consent form I consent to the terms of this agreement

I also agree that Beauty On The spot have the rights not to refund after 14 day of purchase.

Client Name: ----- Clients Signature: -----

Operator signature:----- Date: -----

**Office use only:**

**Laser Treatment Record**

**Client name:** \_\_\_\_\_

**Skin Type Assessment**

Fitzpatrick Skin type I II III IV V VI Ethnicity \_\_\_\_\_

**Hair Assessment**

Areas to be treated \_\_\_\_\_

**Hair density:** Sparse / Medium / Dense **Hair thickness:** Fine / Medium / Coarse

**Hair colour** \_\_\_\_\_ **Hair density** \_\_\_\_\_

Number Session	Date:	Treatment Area:	Fluence/J/cm2:	Client Signature	Therapist Signature	No changes to record card
Session 1						
Session 2						
Session 3						
Session 4						
Session 5						
Session 6						
Session 7						
Session 8						
Session 9						
Session 10						

