Clairderm confidential client card

Client Confidential Details

Name..
Address...
....P/code..........................
Occupation..
Phoe (Day)...A/H...............................
Mobile phone..
Email...
Date of Birth..
Partners Name..Day phone....................
Do you work full time? ☐ Yes ☐ No
How many children do you have?...
Age............ M/F Age............ M/F Age............ M/F Age............ M/F
How did you come to visit the practice?

What service have you had in the past?

What products are you currently using?

Three main areas of concern discussed with the Client

1...
....

2...
....

3...
....

Skin tone: *(check all answers that apply)*

☐ Blonde/fair ☐ Dark hair/light eyes ☐ Irish/red tone
☐ Asian ☐ African ☐ Hispanic
☐ American Indian ☐ Aboriginal ☐ European
Other..

Fitzpatrick type:

☐ 1 ☐ 3 ☐ 5
☐ 2 ☐ 4 ☐ 6

Hair type:

☐ Black ☐ Blond ☐ Grey
☐ Brown ☐ Red ☐ White

Treatments in progress:

(fold along line)

Treatment date..................................Technician..
Treatment...
....
....
Comments...
....
....

Treatment date..................................Technician..
Treatment...
....
....
Comments...
....
....

Treatment date..................................Technician..
Treatment...
....
....
Comments...
....
....

Treatment date..................................Technician..
Treatment...
....
....
Comments...
....
....

Treatment date..................................Technician..
Treatment........ dbbg
dbbg
dbbg
Comments...
....
....

Treatment date..................................Technician..
Treatment...
....
....
Comments...
....
....

Treatment date..................................Technician..
Treatment...
....
....
Comments...
....
....

Treatment date..................................Technician..
Treatment...
....
....
Comments...
....
....

Clairderm consultation, consent & release form

Name:

Phone:

Client Profile

Are you pregnant or trying to conceive? ☐ Yes ☐ No
(Though there are no known contra-indications due to pregnancy, do not perform this treatment during the first trimester of the pregnancy. Have your Client use a Clairderm skin lightening for pigmentations and home product until the end of the first trimester)

Are you using tanning booths? ☐ Yes ☐ No *(if yes decline treatment)*

Have you had collagen or botox injections recently? ☐ Yes ☐ No
(Wait approx. 7 days before/after collagen/botox injections)

Do you have any allergies? if so, specify:

Indicate areas of concern:

☐ Normal	☐ T-Zone/Combination	☐ Cystic Acne
☐ Oily	☐ Comedones	☐ Unven/Blotchy
☐ Dry	☐ Rosacea	☐ Hyperpigmented
☐ Freckled	☐ Broken capillaries	☐ Acne
☐ Scarred	☐ Sun-damaged	☐ Melasma
☐ Saggy	☐ Wrinkles	☐ Milia
☐ Mature	☐ Large pores	☐ Stretch marks
☐ Sensitive skin	☐ Sun damage	☐ Ingrown hair

Have the Client give their own description and make a note of your own professional analysis as well.
What would you like to have corrected?
dbbdf
How long have you been aware of this concern and were previous treatments done to address this concern?
(This is the time to align expectation to reality)
dbbdf

Are you using? ☐ Retin-A ☑ Roacutane ☐ Antibiotics
How frequently? .....
(do not perform this treatment while the Client is on Roacutane. Discontinue use of Retin-A for at least 2 weeks prior to a treatment and at least 6 months following completion of Roacutane)

☐ Hormones/other medication
(Some medications may produce a heightened sensitivity or act as a trigger for hyperpigmentation)

☐ Glycolic/AHA home care products? If so, which one(s)?

How does the skin react to them?

Do you smoke? ☐ Yes ☐ No
(Have the Client understand that smoking may be uncomfortable following the treatment and if the goal is to minimise lip and other lines, the success of the treatment will be limited)

Medical history

☐ Asthma	☐ Diabete	☐ Sinus problem
☐ Cancer	☐ Heart condition	☐ Allergies
☐ Low/high blood pressure	☐ Thyroid disorder	☐ Cold sores

Did the Client sign the Consent Form *(this is just a reminder)?*
☐ Yes ☐ No
(A Client cannot have the treatment without first signing the consent form and therefore agreeing to use a professionally recommended Homecare kit)

Clairderm, Sapphire microdermabrasion system client consent:

Please let us know if you are under any other medical or hormonal treatment which have not been mentioned previously. We require your full cooperation in doing what we ask you to do in between treatments. No swimming for 3 days and no exposure to the sun after treatment.

✔ I understand there may be some degree of discomfort. I understand I may experience some discomfort and redness, tingling, irritation in some cases for a short period of time with having this treatment/procedure.

✔ I understand there are no guarantees as to the results of this treatment, due to many variables, such as: age, hair colour, condition of skin, sun damage, smoking, climate, etc. I understand that each case is individual.

✔ I understand this treatment is a cosmetic treatment and that no medical claims are expressed or implied.

✔ I understand that to achieve maximum results, I may need several treatments.

✔ I understand that although complications are very rare, sometimes an unexpected outcome may occur and that prompt treatment is necessary. In the event of any unexpected outcome, I will immediately contact the doctor/technician who performed the treatment.

✔ I agree to refrain from tanning in tanning booths while I am undergoing treatment, and during the 14 days following the end of treatment.

✔ I have not had any other peel, microdermabrasion or laser treatment of any kind within 7-14 days of the treatment. I understand that I cannot have another treatment within 7-14 days of this treatment, whether the treatment is performed at this location or any other location.

✔ I hereby agree to all of the above and agree to have this treatment be performed on me. I further agree to follow all post procedure care instructions as I am directed.

Signature of Client:

Date: svdds

Signature of Technician:

Date: svdds

Consent Review:

Treatment Date: dfbdf	Initials:
Treatment Date: dfbdf	Initials:
Treatment Date: dfbdf	Initials:
Treatment Date: dfbdf	Initials:
Treatment Date: dfbdf	Initials:
Treatment Date: dfbdf	Initials:
Treatment Date: dfbdf	Initials:
Treatment Date: dfbdf	Initials: