CLEAR TOE INTAKE INFORMATION

Name: _____ **Today's Date**: _____
Last First MI

Street address: _____

City: _____ **State:**_____ **Zip**:_____

Date of birth: _____ **Age:** _____ **Sex**: ☐ Female ☐ Male

Home Phone: _____ **Cell Phone:** _____

Leave messages at: ☐ Home ☐ Cell ☐ Other: _____

Email address: _____
I consent to this email address being added to the MedSpa at Hendrick email newsletter, where I will get information on specials and promotions. ☐**Yes** ☐**No**

Occupation:_____

Primary Care Physician/phone number: _____

In case of Emergency, who should be notified? (name and phone)
_____

Unless otherwise indicated, we have permission to communicate changes in your health status, including surgery, to other physicians participating in your care. ☐ Yes, may notify ☐ No, please do not notify.

Do you have any major medical problems, serious illness? ☐ Yes ☐ No If so, please list:

_____

_____

Please list all prior surgical procedures and dates performed:

_____

_____

Please list all injectable procedures (Botox, Juvederm, Restylane, Collagen, etc) and dates performed:

_____

_____

MEDICAL HISTORY

Do you have a pacemaker or defibrillator? ☐ Yes ☐ No

Do you suffer from "photosensitivity" (extreme sensitivity to sunlight)? ☐Yes ☐ No

Do you have a history of easy/excessive Hyperpigmentation? ☐Yes ☐No

Do you form keloid scars? ☐Yes ☐No

Do you suffer from seizures? ☐Yes ☐No

Do you have any metal implants? ☐Yes ☐No

Do you wear contact lenses? ☐Yes ☐No

Have you taken Accutane, Retin A or Renova in the past 12 months? ☐Yes ☐No

Are you currently taking Coumadin (Warfarin) or other blood thinners? ☐Yes ☐No

Do you require antibiotics before procedures such as dental cleanings? ☐Yes ☐No

Do you smoke? ☐Yes ☐No If yes packs per day? _____

Do you drink alcohol? ☐Yes ☐No If yes quantity per week? _____

Have you ever had an adverse reaction to laser or cosmetic treatments? ☐Yes ☐No

If so, please list: _____

Are you allergic to any medications? ☐Yes ☐No
If so, please list:
_____

Do you have any other allergies? ☐Yes ☐No
If so, please list:
_____

Do you take any of the following (please check all that apply and/or list additional medications):

- ☐ Antibiotics
- ☐ Anti-coagulants
- ☐ Anti-depressants
- ☐ Appetite depressants
- ☐ Aspirin or Ibuprofen
- ☐ Blood Pressure Medication
- ☐ Cortisone or steroids
- ☐ Hormones/contraceptives
- ☐ Insulin
- ☐ NSAIDS
- ☐ Sedatives
- ☐ Thyroid Medication
- ☐ OTHER _____
- ☐ OTHER _____

Are you taking herbal preparations or vitamins (St. John's Wort, Vitamin E, etc.)? ☐Yes ☐No
Are you or might you be pregnant? ☐Yes ☐No
Are you trying to become pregnant? ☐Yes ☐No
Are you nursing? ☐Yes ☐No

Have you ever had any problems with any of the following anesthetics? If so, please specify.
☐**Block** (e.g. dental): Ineffective / Heart palpitations / Systemic reaction/ Other _____
☐**Local**: Ineffective / Heart palpitations / Systemic reaction / Other _____
☐**Topical:** Ineffective / Heart palpitations / Systemic reaction / Other _____

Have you ever had or do you have any of the following *(please check all that apply):*

- ☐ Active Infection
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Blistering Sunburns
- ☐ Circulation Problems/Blood Clots
- ☐ Cold Sores / Shingles
- ☐ Collagen Disorder
- ☐ Diabetes (Type)
- ☐ Easy Bruising
- ☐ Eczema
- ☐ Endorcrine / Hormonal Issues
- ☐ Eye Problems
- ☐ Fatigue
- ☐ Fibromyalgia
- ☐ Headaches / Migraines
- ☐ Heart Condition
- ☐ Hepatitis
- ☐ High / Low Blood Pressure
- ☐ HIV/AIDS
- ☐ Hormonal Imbalance
- ☐ Insomnia / Sleeping Problems
- ☐ Joint Injury
- ☐ Multiple Sclerosis
- ☐ Muscle Pain / Spasms
- ☐ Neurological Disorders
- ☐ Permanent Makeup / Tattoo
- ☐ Pigmentation Disorders
- ☐ Psoriasis
- ☐ Melanoma
- ☐ Recent Surgery
- ☐ Scleroderm
- ☐ Sensitive Teeth
- ☐ Skin Cancer
- ☐ Skin Injury
- ☐ Stroke
- ☐ Unusual Moles
- ☐ Varicose Veins
- ☐ Vision Deficits
- ☐ OTHER _____

SKIN CARE HISTORY AND CONCERNS

Please list any products that irritate your skin:

_____

_____

Have you had unprotected sun exposure or been in a tanning booth in the *last 2 weeks*?
☐Yes ☐No

Do you use self tanners? ☐Yes ☐No If yes, when was last application? _____

Are you planning a vacation in the sun in the next 3-6 months? ☐Yes ☐No

Have you used any of the following hair removal methods in the *past 6 weeks*?:
☐Shaving ☐Waxing ☐Electrolysis ☐Plucking/Tweezing ☐Stringing ☐Depilatories

Please indicate your current skin care products/regimen:

_____

_____

_____

Therapist/Provider Reviewed (sign) _____ **Date** _____

MY SPECIFIC CONCERNS AND INTERESTS

(Please check all that apply and indicate any prior treatments in space provided.)

CONCERNS	**List any prior treatment and approximate date(s):** (Accutane/Botox/Peels/IPL/Lasers/Surgery/etc.)
☐ Dry or Oily Skin	
☐ Skin discoloration	
☐ Brown Spots	
☐ Acne	I have used Accutane: □ YES □ NO Last Dose:_____
☐ Rosacea	
☐ Fine Wrinkles	
☐ Deep Wrinkles	
☐ Lip Lines	
☐ Thin Lips	
☐ Nasolabial Creases	
☐ Marionette Lines	
☐Loose Skin	
☐Ageing Hands	
☐Excessive Sweating	
☐Facial/Body Hair	
☐Scars	
☐Facial Veins	
☐Leg Veins	
☐Not Certain	
☐Toenail Fungus	
☐CoolSculpting/body contouring	
☐Other	

Client Signature :_____**Date:**_____

Provider Signature:_____ Date:_____

ACKNOWLEDGEMENT OF PRACTICE POLICIES

I understand that I will receive traditional spa or cosmetic medical treatment from the MedSpa at Hendrick. Some of the various treatments the MedSpa at Hendrick provides include: massage therapy; facials; waxing; chemical peels; microdermabraison; laser hair removal; photorejuvenation/BBL; skin resurfacing; skin tightening; CoolSculpting; Botox® Cosmetic injections and filler injections. I understand that depending on the treatment I select, I will be required to sign an informed consent specific to that treatment. **_____ (Please Initial).**

I am fully aware that my condition is solely of a cosmetic nature and that the decision to proceed is based on my expressed desire to do so: **_____ (Please Initial).**

Payment Policy

I understand that my treatments at the MedSpa at Hendrick require payment and the prices and fee structure for treatment have been explained to me. The quoted price for treatment is the price for each individual treatment session, unless otherwise specified in writing by the MedSpa at Hendrick. For cosmetic medical procedures, I understand that the services often require more than one session for best outcome, and I have the option of purchasing a series/package of treatment sessions at the quoted package price. There is no guarantee of refunds on treatments paid in advance. Any refunds will be determined on a case by case basis after appropriate management approval. I further understand that the services offered by the MedSpa at Hendrick are elective in nature and are not covered by health insurance. I agree to pay for the treatment according to the payment plan discussed. We accept payment in the form of cash, check or most major credit cards._____ **(Please Initial).**

Cancellation and Late Policy

I am aware that the MedSpa at Hendrick **requires 24 hours notice of a cancellation** and that it is my responsibility to provide timely notice by calling the MedSpa at Hendrick. **I agree to pay a $25.00 fee if I fail to give the required 24 hours notice**. If I have prepaid my treatment session or sessions, I understand that I may forfeit one of my future sessions if I do not provide the MedSpa at Hendrick with the required 24 hours notice. _____ **(Please Initial).**

The MedSpa at Hendrick asks that I arrive **15 minutes prior** to each of my scheduled appointment time(s) so that all appointments can run both efficiently and timely. **Late arrivals may result in a reduction of treatment time or appointment being rescheduled**, **along with a cancellation fee of $25.00 if appointment has to be rescheduled._____ (Please Initial).**

Return Policy

All sales of skin care and makeup products are final. Unopened products may be returned with a receipt for a credit within 30 days. **_____ (Please Initial)**

Disclaimer

I understand that all medical cosmetic treatments are provided exclusively by the MedSpa at Hendrick. I will not hold the MedSpa at Hendrick, its owners or its employees responsible for the results I experience. I realize that results may vary. I further understand that the MedSpa at Hendrick cannot prescribe an exact number of treatments to satisfy each individual's opinion and that the number of treatments I complete will be at my own discretion: _____ **(Please Initial).**

I understand that even with the best laser and the highest trained technicians, as high as 10-15% of patients will not have a desired response/outcome to treatments. _____ **(Please Initial).**

Privacy

I have received a copy of the Hendrick Medical Center Notice of Privacy Practices. _____ **(Please Initial).**

I have read and fully understand all the terms of this Acknowledgement of Practice Policies form, all my questions have been answered to my satisfaction and I agree to the terms of this consent:

Print Patient Name: _____ Patient Signature: _____ Date: _____

I have explained the above statements to the client and answered all questions.

Clinical Staff Name: _____ Clinical Staff Signature:_____ Date: _____