Electrology Essentials

Website: www.electrologyessentials.com

Client Health History Assessment

Electrology Essentials
1507 E Sunset Dr. #140
Waukesha, WI 53189
Phone: (414) 303-0660

Primary Information

Today's Date: ____________ M D Y Date of Birth: ____________ M D Y

Legal First Name: ____________ Middle Initial: ____ Legal Last Name: ____________

Preferred Name: ____________ Gender Identified as: ____________

Street Address: ____________ City: ____________ State: ______ Zip Code: ______

Phone: home /mobile ( ) ____________ Email: ____________

How can we contact you for appointment changes & reminders? Select all that apply Call Text Email

Emergency Contact Name: ____________ Phone: ( ) ____________ Relationship: ____________

Hair Removal Information

Areas you are considering for treatment? { select all that apply }

Head: Lip Mustache Chin Beard Eyebrows Uni-brow Ears Nose Sideburns Hairline Neck

Body: Armpits Breast Chest Navel Happy-Trail Bikini Groin Anus Penis Shaft Upper Back Lower Back

Limbs: Shoulders Upper Arms Lower Arms Hands Fingers Outer Thighs Inner Thighs Lower Legs Feet Toes

Other: ____________

Hair Removal Methods

What temporary hair removal methods do you frequently use?{Select all that apply} Waxing Sugaring Tweezing Creams Threading Other

Frequency ____Times ____ Times ____ Times____ Times____Times ____Times____

Per:

Have you ever had **Laser Hair Removal** before? yes / no Laser Hair removal company: ____________

Date of last treatment: ____________ Area/Body Part/s Treated: ____________

Skin reactions to Laser hair removal? (Describe) ____________

Have you ever had **Electrolysis? Yes / No** Electrologist's name: ____________ Address: ____________

Date of last treatment: ____________ Area/ Body Part/s treated: ____________

Total # of treatments: ____________ Modality: {select all that apply} Thermolysis Blend Galvanic Not Sure

Skin reactions to **any** previous hair removal methods?{Select all that apply} None Redness Swelling Ingrown Hair Infection Bumps/Pimples

Other:: ____________

Sudden onset of hair growth? Yes / No Describe: ____________

Other Information

How did you hear about us? If referral, by who? ____________

Other: ____________

Photo Consent

For the purpose of documentation, I consent to photographs before treatment, mid-treatment, and upon completion. yes / no **Initials:** ______

- Please note: These photos will NOT be used for marketing of any kind.
- Your electrologist requires you to consent to photographs for their professional confidential files.

Does Electrology Essentials have permission to document your hair removal process through your story, pictures and or videos and use them for it's print and/or digital media publications? Photographs yes / no **Initials:** ______ Videos: yes / no **Initials:** ______

Client Comments & Questions: ____________

____

ELECTROLOGIST RECOMMENDED TREATMENT PLAN: (Estimated) 1- 4 months: Frequency ____________

4-8 months: Frequency____________ 8-12 months: Frequency____________ 12-16 months: Frequency____________ 16-24 months____________

- The estimated treatment plan depends on the client's full cooperation and commitment to achieving the best possible result.
- Keeping regular appointments, following the aftercare advice of your electrologist, and abiding to the recommended temporary hair removal options between appointments.
- Client understands that this plan may change due to unforeseen non/ or hormonal hair growth changes, from medications, surgery, or other physiological changes.

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Client Health History Assessment

Health Information

List All Medications & Vitamins that you are currently taking:

Name	Purpose	Name	Purpose

List All Allergies (including any "caine"numbing products)

Name	Comments	Name	Comments

Health Conditions Present or Past: {select all that apply}

Acne/Retin A Body Piercings Breathing Problems Cancer Cardiovascular Disease Clotting Issues COPD Diabetes Pigment Problems
Dizziness/Fainting Heart Attack Healing Issues Hepatitis Herpes/Cold Sores High Blood Pressure HIV/Aids Metal Implants Keloids
Kidney Disease Pacemaker Piercings PCOS Infertility TB Thyroid Disease Skin Tags Stroke HPV/Warts

Other: ______________________________

Dermplaning: yes / no Last treatment: ___/___/___ (M D Y) Micro-needling: yes/ no Last treatment: ___/___/___ (M D Y)

Are you pregnant? yes / no Do you get your period? yes / no If yes, is it regular? yes / no

Have you traveled outside of the country in the last 30 days? yes / no Where: ____________ Covid-19 Exposure/ Symptoms? yes / no

Have you had any major surgeries? yes / no Specify: ______________________________

Are you preparing for sex reassignment surgery? yes / no **(If NO, skip to next section)** Planned Date of Surgery: ___/___/___ (M D Y)

Physician's Name: ______________________________ Phone: (   ) ____________

Physician's Address: ______________________________ May we contact to discuss your treatment plan?

Client Acknowledgement of Information

I understand health history information is important to my Electrologist in order to provide me with safe and effective electrology treatments. I acknowledge all information given to me is accurate to the best of my knowledge, and I agree to update my health history assessment whenever there are changes.

__________ Initials

I have been advised of the post-treatment care, the healing process and the possible risks related to treatment. I agree to follow all aftercare instructions and to notify my Electrologist of any concerns or difficulty in healing.

__________ Initials

I understand that a series of treatments is necessary to achieve permanent hair removal, and my progress will be impacted by my personal hair growth rate, the science of electrology, my individual physiological factors, and if I follow the recommended treatment plan, and keep treatments consistent.

__________ Initials

I understand my Electrologist has the right to refuse treatment if it is not beneficial to my health or skincare due to known or unknown health conditions I may have.

__________ Initials

Client Name:____________________ Signature: ____________________ Date: ___/___/___ (M D Y)

If under 18, parent/guardian must sign.

Parent's Name:____________________ Parent's Signature: ____________________ Date: ___/___/___ (M D Y)