Electrology Essentials

Website: www.electrologyessentials.com

# Client Health History Assessment

**Electrology Essentials**
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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: Month Month Month Month Month Month

Have you ever had **Laser Hair Removal** before? 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?** 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? No Describe: _____

## Other Information

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

Other: _____

### Photo Consent

For the purpose of documentation, I consent to photographs before treatment, mid-treatment, and upon completion. 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 No **Initials:** _____ Videos: 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? No Do you get your period? No If yes, is it regular? No

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

Have you had any major surgeries? No Specify: _____

Are you preparing for sex reassignment surgery? 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? No

## 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)