Electrology Essentials

Website: https://electrologyessentials.squarespace.com

Client Health History Assessment

Electrology Essentials
1426 S West Ave
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: _____ Email: _____

How can we contact you for appointment changes and 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						
Per:						

Have you ever had **Laser Hair Removal** before? ☐ Laser Hair removal company: _____

Date of last treatment: _____ Area/Body Part/Treated _____

Skin reactions to Laser hair removal? (Describe) _____

Have you ever had **Electrolysis?** ☐ 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? ☐ Describe: _____

Other Information

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

Other: _____

Media Release

Does Electrology Essentials have permission to document your hair removal process through your story, pictures and or videos ?

and use them in its print and/or digital publications? Photographs: ☐ Videos: ☐ Initials: _____

Client Comments & Questions:

_____

_____

_____

_____

_____

_____

_____

_____

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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/ Describe marked items _____

Dermabrasion: ☐ Last application: _____ (M D Y)

Are you pregnant? ☐ Do you get your period? ☐ If yes, is it regular? ☐

Have you traveled outside of the country in the last 30 days? ☐ Where: _____ Covid-19 Exposure/Symptoms? ☐

Have you had any major surgeries? ☐ Describe _____

Are you preparing for sex reassignment surgery? ☐ 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 from me is accurate, to the best of my knowledge, and I agree update my health history assessment whenever there are changes. _____ 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, and my individual physiological factors. _____ 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 after-care instructions, and to notify my Electrologist of any concerns or difficulty in healing. _____ 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)