NAME:	DATE:
PHONE:	EMAIL:
OCCUPATION:	
WHAT IS YOUR HEREDITARY BACKGROUND:	
HOW WOULD YOU DESCIRBE YOUR SKIN TYPE: PLEASE CIRCLE ONE	OILY COMBINATION DRY VERY DRY
HAVE YOU RECEIVED ANY OF THE FOLLOWING, IF YES, PLEASE CIRCLE:	CHEMICAL PEEL MICRODERMABRASION DERMAPLANING FACIAL LASER HAIR REMOVAL EYELASH/BROW TINT WAXING
HAVE YOU USED ANY OF THE FOLLOWING TOPICAL/ORAL MEDICATIONS, IF YES, PLEASE CIRCLE:	ACCUTANE RENOVA HYDROQUINONE DIFFERIN TAZARAC TOPICAL ANTIBIOTICS RETIN-A TRENTINOIN ALPHA HYDROXY ACIDS AVAGE EPIDUO ZIANA
ARE YOU ON ANY MEDICATION IN ANY FORM AT ALL? LIST VITAMINS, SUPPLEMENTS, ORAL MEDS, INJECTABLES, ETC. PLEASE:	
HAVE YOU HAD ANY RECENT INJURIES? EXPLAIN: (TREATMENTS TYPICALLY INCLUDE HAND/ARM, FOOT/CALVE, HEAD, NECK, SHOULDER MASSAGES - SPECIFY IF YOU HAVE CONCERNS ABOUT THIS PLEASE)	YES / NO

DO ANY OF THE FOLLOWING IMPACT YOU (CIRCLE):	HEART CONDITIONS
COLD SORES	CANCER
PREGNANCY	HIGH BLOOD PRESSURE
DIABETES	CYSTIC ACNE
SUNBURN (CURRENTLY)	SEVERE ECZEMA
PINK EYE (CONJUNCTIVITIS)	ALLERGIC REACTIONS
MIGRAINES	SEIZURES
BLEEDING DISORDERS (I.E. ANEMIA)	HIV/AIDS
SKIN DISORDER (I.E. DERMATITIS)	HYPERTROPHIC SCARING (I.E. KELOIDS)
SEVERE PSORIASIS	ROSACEA
HEPATITIS	PACEMAKER/METAL IMPLANTS
FUNGAL INFECTIONS	ANXIETY
ARTHRITIS	THYROID DISEASE
OTHER:	

NOTE: IF ANY CONDITIONS ARE ACTIVE AND CONTAGIOUS WE RESERVE THE RIGHT TO REFUSE TREATMENT FOR THE HEALTH AND SAFETY OF THE CLIENT, THE PROVIDER, AND FUTURE CLIENTS

Contraindications for high frequency, microcurrent, ultrasonic cleaning and LED Therapy include: epilepsy, pregnancy, heart conditions, pacemaker, metal plates or pins, excessive fillings or bridgework, cancer within the last 2 years, thrombosis, diabetes, recent Botox or fillers (please wait at least two weeks)

Do you give consent for discreet photos to be taken and used for professional posts and blogs in the future? (names will never be shared)	YES / NO
HAVE YOU, OR ANYONE IN YOUR HOME, BEEN SICK IN THE LAST 7 DAYS (COLDS OR FLU BUGS)	YES / NO
WHAT MOTIVATES YOU WHEN CHOOSING A SKIN CARE PRODUCT LINE? (I.E. PRICE, EFFECTIVENESS, PACKAGING LOOKS COOL, ETC.)	
DO YOU CONSUME TOBACCO PRODUCTS? IF YES, PLEASE LIST	

HOW OFTEN TO YOU EXCERSIZE TO THE POINT WHERE YOU SWEAT?	NEVER / 1-3 TIMES A WEEK / 4+ TIMES A WEEK
DO YOU CONSUME CAFFEINE?	YES / NO
HOW MANY OUNCES OF WATER DO YOU DRINK DAILY?	
DO YOU EAT AT LEAST 3 FULL SERVINGS OF FRUITS & VEGETABLES A DAY?	YES / NO
WHAT IS YOUR PRIMARY SOURCE OF PROTEIN?	
ARE YOU IN THE HABIT OF USING TANNING BEDS?	
DO YOU WEAR CONTACT LENSES OR EYEGLASSES?	
ARE YOU TAKING AN ORAL CONTRACEPTIVE:	YES / NO LIST NAME: HOW LONG HAVE YOU BEEN ON THIS:
ARE YOU PREGNANT, LACTATING, MENOPAUSAL, RECENTLY WITHOUT CHILD OR UNDERGOING HORMONE REPLACEMENT THERAPY?	YES / NO
LIST YOUR TOP 3 MAIN CONCERNS ABOUT YOUR SKIN IN ORDER OF IMPORTANCE:	
DESCRIBE WHAT YOUR SKIN WAS LIKE DURING PUBERTY: (SKIP IF YOU ARE EXPERIENCING PUBERTY)	
HAVE YOU EVER HAD AN ALLERGIC REACTION? IF YES, PLEASE EXPLAIN	YES / NO

WHAT PRODUCTS ARE YOU CURRENTLY USING AND WHEN:

PLEASE LIST THE PRODUCT NAME

MORNING ROUTINE:	BEDTIME ROUTINE:
CLEANSER:	EYE MAKEUP REMOVER:
TONER:	CLEANSER:
EXFOLIANT:	TONER:
MASK:	EXFOLIANT:
SERUMS:	MASK:
MOISTURIZER:	SERUMS:
SPF:	MOISTURIZER:
MAKEUP:	

HAVE YOU EVER HAD INJECTIONS: BOTOX, RESTYLANE, COLLAGEN, ETC	YES / NO *WHEN WAS LAST INJECTION:*
DO YOU UNDERSTAND THAT EVERY PROCUDERE/TREATMENT IS FOLLOWED BY A PERIOD OF HEALING BEFORE THE TISSUE RETURNS TO NORMAL AND THE FINAL RESULT IS APPARENT?	*YES / NO*
DO YOU UNDERSTAND THAT THE OBJECTIVE OF ANY COSMETIC TREATMENT IS AN IMPROVEMENT, NOT PERFECTION, AND THAT RESULTS TAKE TIME AND CONSISTENCY?	*YES / NO*

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof.

CLIENT SIGNATURE:	*DATE:*
PARENT/GUARDIAN SIGNATURE (IF UNDER 18 YEARS)	*DATE:*

THE REFINERY
ESTHETICS BAR + WELLNESS CENTER

2126 B WISCONSIN AVE NEW HOLSTEIN WI 53061 - OWNED AND OPERATED AS AN LLC

CONSENT TO DERMAPLANING FOR COSMETIC PURPOSES

1. I HEREBY REQUEST AND AUTHORIZE THIS PRACTICE TO TREAT ME FOR THE PURPOSE OF ATTEMPTING TO IMPROVE MY APPEARANCE.

2. I UNDERSTAND THAT DERMAPLANING IS A MANUAL, NON-INVASIVE PROCEDURE THAT REMOVES THE SUPERFICIAL LAYER OF THE SKIN AS WELL AS THE VELLUS HAIR ON THE SKIN'S SURFACE BY THE USE OF A STERILE BLADE.

3. THE EFFECT AND NATURE OF THE TREATMENT TO BE GIVEN HAS BEEN EXPLAINED TO ME. I ACKNOWLEDGE THAT THE GOAL OF THE TREATMENTS IS TO INDUCE IMPROVEMENTS IN MY SKIN, BUT INDIVIDUAL RESULTS MAY VARY.

4. I ACKNOWLEDGE THAT NO GUARANTEE HAS BEEN GIVEN TO ME AS TO THE NUMBER OF MONTHS/YEARS THAT I MAY APPEAR YOUNGER FOLLOWING TREATMENT.

5. I ACKNOWLEDGE THAT NO GUARANTEE HAS BEEN GIVEN TO ME AS TO THE AMOUNT OF IMPROVEMENT EXPECTED FOLLOWING TREATMENT.

6. I ACKNOWLEDGE THAT I HAVE NOT TAKEN ACCUTANE OR ISOTETINOIN IN THE PAST 12 MONTHS. I FURTHER AGREE NOT TO TAKE ACCUTANE OR ISOTRETINOIN DURING MY TREATMENT PROGRAM AT THIS PRACTICE AND FOR SIX MONTHS AFTER ENDING MY TREATMENT AT THIS PRACTICE.

7. I UNDERSTAND THAT I MUST APPLY A HYPOALLERGENIC, HYDRATING, ANTIOXIDANT TOPICAL PREPARATION TO ENCOURAGE EPIDERMAL REGENERATION, FOR AT LEAST 1 WEEK POST PROCEDURE.

8. I HAVE BEEN ADVISED THAT A BROAD SPECTRUM SUNSCREEN MUST BE USED FROM THE DATE OF MY FIRST TREATMENT AND CONTINUED DAILY THEREAFTER. I AGREE TO APPLY THAT A BROAD SPECTRUM SUNSCREEN DAILY._____(INITIAL)

9.THE FOLLOWING CONDITIONS (INCLUDING BUT NOT LIMITED TO) LISTED BELOW ARE NOT TREATABLE WITH DERMAPLANING: IMPETIGO, INFLAMED ECZEMA, HERPES SIMPLEX, SEVERELY DISTENDED CAPILLARIES, DERMATITIS, QUESTIONABLE LESIONS, AND SUNBURN.

10. POSSIBLE SIDE EFFECTS FROM TREATMETN INCLUDE: SCRAPING, CUTTING, OR ABRADING THE SKIN WITH THE BLADE, STINGING, TENDERNESS, FLAKING, PEELING, OF THE SKIN AND/OR MILD TO MODERATE REDNESS. IT IS POSSIBLE THAT ONE OR MORE OF THESE SIDE EFFECTS MAY LAST FOR 1-3 DAYS POST PROCEDURE. HOWEVER, MOST SUBSIDE WITHIN 24 HOURS.

11. I CERTIFY THAT ALL INFORMATION PROVIDED TO THIS PRACTICE IS TRUE AND ACCURATE. IA GREE TO FOLLOW PROTOCOL OUTLINED ABOVE. I AGREE TO HOLD HARMLESS THIS PRACTICE AND ITS AGENTS FOR ANY ADVERSE REACTIONS DUE TO OMITTED INFORMATION AND/OR MISINFORMATION ON THE CLIENT HEALTH QUESTIONNAIRE AND/OR FROM ACTIONS WHICH DEVIATE FROM PRE AND POST CARE PROCEDURES.

12. I UNDERSTAND THAT CHEMICAL TREATMENTS AND DERMAPLANING MAY CAUSE A FLARE-UP OF THE HERPES SIMPLEX VIRUS (COLD SORES).

13. I HAVE BEEN ADVISED TO AVOID OR DISCONTINUE THE FOLLOWING TREATMETNS FOR AT LEAST 2 WEEKS PRIOR TO AND FOLLOWING MY TREATMENT:

A. ALL INJECTABLES INCLUDING BUT NOT LIMITED TO BOTOX, XEOMIN, COLLAGEN, SCULPTRA, JUVADERM

B. RETIN-A, RENOVA, AND ALL RETINOIC ACID PRODUCTS

C. ALL ALPHA AND BETA HYDROXY ACID PRODUCTS

(I.E. BIOELEMENTS SLEEPWEAR, SKIN EDITOR, AGE ACTIVIST)

_____ _____

CLIENT SIGNATURE AND DATE PARENT/GUARDIAN SIGNATURE AND DATE

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