Client History Profile Form

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| --- | --- | --- | --- |
| Name: | Date: | Gender: | Age: |
| Street Address: | City: | State: | Zip: |
| Phone Number: | Alt. Number: | Email: | How did you hear about us: |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 1 | YES | NO | ARE YOU PREGNANT/NURSING? | 15 | YES | NO | DO YOU SMOKE? |
| 2 | YES | NO | HAVE YOU CONSUMED ANY ALCOHOL OR BLOOD THINNERS WITHIN 24 HOURS? | 16 | YES | NO | DO YOU HAVE ANY AUTOIMMUNE DISORDERS? |
| 3 | YES | NO | ARE YOU ALLERGIC TO LIDOCANE, TETRACAINE, BENZOCAINE OR WHITE PETROLEUM? | 17 | YES | NO | HAVE YOU CONSUMED ANY CAFFIENE TODAY? |
| 4 | YES | NO | HAVE YOU HAD A LASER OR CHEMICAL PEEL IN THE LAST 6 WEEKS? | 18 | YES | NO | DO YOU TEND TO DEVELOP KELOIDS OR HYPERTROPY SCARS? |
| 5 | YES | NO | HAVE YOU EVER HAD ANY COSMETIC TATTOOS APPLIED? | 19 | YES | NO | DO YOU SCAR EASILY FROM MINOR INJURIES? |
| 6 | YES | NO | DO YOU USE RETIN-A, GLYCOLIC OR OTHER EXFOLIATING PRODUCTS? | 20 | YES | NO | DO YOU HAVE ANY SEIZURE RELATED CONDITIONS? |
| 7 | YES | NO | ARE YOU ALLERGIC OR SENSITIVE TO ANY METALS? (EXAMPLE: JEWELERY) | 21 | YES | NO | DO YOU TEND TO GET FAINT OR DIZZY? |
| 8 | YES | NO | DO YOU HAVE DIFFICULTY HEALING FROM SMALL WOUNDS? | 22 | YES | NO | DO YOU BLEED EXCESSIVELY FROM MINOR CUTS? |
| 9 | YES | NO | DO YOU HAVE EXTRA DRY/OILY SKIN? | 23 | YES | NO | DO YOU CONSUME ASSPRIN DAILY? |
| 10 | YES | NO | DO YOU GET BOTOX OR SIMILAR INJECTIONS? | 24 | YES | NO | DO YOU HAVE ROSACEA? |
| 11 | YES | NO | ARE YOU UNDERGOING RADIATION OR CHEMOTHERAPY? | 25 | YES | NO | DO YOU TAKE PERSCRIPTIONS THAT CAUSE YOUR BLOOD OR SKIN TO THIN? |
| 12 | YES | NO | HAVE YOU TAKEN ACCUTANE IN THE LAST 12 MONTHS? | 26 | YES | NO | DO YOU HAVE ANY DISEASES/DISORDERS THAT ARE TRANSMITTED THROUGH BLOOD CONTACT? |
| 13 | YES | NO | DO YOU TAN INDOOR/OUTDOOR REGULARLY? | 27 | YES | NO | ARE YOU CURRENTLY MENSTRATING? IF SO, YOUR SENSITIVITY MAY BE HEIGHTENED |
| 14 | YES | NO | ARE YOU ANEMIC? | 28 | YES | NO | DO YOU TEND TO GET FEVER BLISTERS/COLD SORES? |

IF YOU ANSWERED “YES” TO ANY OF THE QUESTIONS LISTED ABOVE, PLEASE USE THE SPACE BELOW TO ROVIDE A BREIF EXPLANATION AND CORRELATE YOUR ANSWERS TO THE SPECIFIC QUESTION NUMBER. A “YES” DOES NOT NECESSARILY INDICATE THAT YOU AREN’T AN ACCEPTABLE CANDIDATE FOR PERMANENT COSMETICS. IT MAY SIMPLY BE INFORMATION THAT IS VALUABLE TO ME AS YOUR TECHNICIAN. EACH PERSON’S BODY IS UNIQUE AND CERTAIN HEALTH CONDITIONS THAT AFFECT HEAING MAY REQUIRE YOU TO CONSULT WITH YOUR PHYSICIAN BEFORE PROCEEDING. IF A MEDICAL CONDITION APPLIES TO YOU THAT IS NOT LISTED, PLEASE ADD THAT INFORMATION AS WELL AND INFORM YOUR TECHNICIAN.

**INFORMED CONSENT FOR PERMANENT COSMETICS**

PLEASE INITIAL BELOW:

( ) I acknowledge by signing this agreement that I have been given full opportunity to ask any questions I may have and that all of my questions have been answered to my full and total satisfaction. I specifically acknowledge that I have been advised of the facts set forth below and agree as follows:

( ) I release all rights to any photographs and videos taken and give my complete Advance consent for their reproduction in any form.

( ) I do not have a history of or currently have diabetes, epilepsy, hepatitis, hemophilia, HIV, AIDS, tuberculosis, or any other communicable disease. I also do not have an allergy to antibiotics, a heart condition, rosacea and I am not currently receiving chemotherapy.

( ) I do not have a history of or currently take medicine that may thin my blood.

( ) I am not under the influence of drugs or alcohol.

( ) I don't have a medical or skin condition, such as, but not limited to acne, scarring, eczema, psoriasis, freckles, moles, or sunburn, in the areas to be tattooed.

( ) If I have a history of or currently have any of the aforementioned conditions, by initially here I am acknowledging that I have spoken with my medical provider and I have insurance that this is a safe procedure for me to receive.

( ) I am not currently pregnant or breastfeeding.

( ) I acknowledge that this procedure is a permanent change to my appearance. To my knowledge I do not have any physical, mental, or medical impairment which might affect my decision to have the technician provide this procedure.

( ) I acknowledge that I have truthfully represented myself to be 18 years of age or older, with a valid driver's license as identification.

( ) I understand that microblading/Semi permanent Cosmetics/cosmetic tattooing micro pigment implantation is the process of implanting microinsertions of pigment into the dermal layer of the skin. Micropigment implantation is a form of tattooing used for the purpose of semi-permanent cosmetic tattooing.

( ) I understand that there may be unknown risks and Hazards related to the performance of the procedure and I understand that there is no warranty or guarantees that have been made to me about the results.

( ) Due to the fact that my approval is obtained prior to my permanent cosmetic design / shape and color choice, I understand that no refunds are to be given.

( ) I understand that there are a number of variables that affect the healing process and pigment retention, and that every clients results are different. These variables have been explained to me.

( ) I understand the possible risks involved in this procedure such as but not limited to:  infection, allergic reaction to pigments used or products used during the procedure, Fanning or spreading of the pigment, and fading of the pigment. I have been given the opportunity to ask any questions that I may have about any of these issues.

( ) I understand that allergic reactions are extremely rare however they can occur. If they do occur, they may be difficult to treat.

( ) I acknowledge the manufacturer of the pigments suggest a spot test and specifically disclaims any responsibility for any adverse reaction to applied pigments. I understand that spot testing may identify individuals who develop an immediate allergic reaction to pigment. However, spot testing may not identify individuals who may have delayed allergic reactions.

( ) I agree to receive OR waive a spot test by my permanent cosmetic technician prior to application and I agreed to release the technician in pigment manufacturer from any and all liability related to allergic reactions.

( ) I understand that while there will be a topical anesthetic used that the procedure may cause pain and discomfort. I agree to sit through the entire process despite this.

( ) I understand that this is to be considered a permanent procedure and there is a chance of hyperpigmentation, especially in individuals that are prone to hyperpigmentation and scarring.

( ) I agree to book a 4 to 6 week follow up appointment. I understand that some clients may require additional work to achieve their final desired look and that this can be done at an additional cost.

( ) I agree to accept full responsibility for any and all, present and future, Medical Treatments and expenses I may incur in the event I need to seek treatment for any known or unknown reason associated with this procedure.

( ) In the event of a CAT scan or MRI, I understand that tattoos may cause a warming, burning and/or tingling sensation in the permanent cosmetic procedure area due to iron oxide properties in some pigments. I Should Have Eyes my position that I have permanent cosmetics in the event of an MRI or CAT scan.

( ) The fee for permanent cosmetic procedures has been explained to me and has been agreed upon. I understand the total fee for services rendered is due upon completion of the initial procedures and that there will be separate fees for any future modifications of the design(s) or major color change(s).

( ) I certify that this form has been fully explain to me and then I have read it and fully understand its contents.

( ) I have received Aftercare instructions. I have asked any questions I might have and I fully understand the instructions.

**CLIENTS FULL NAME:**

**DRIVER’S LICENSE # AND STATE ISSUED:**

**ADDRESS:**

**PHONE NUMBER:**

**EMAIL ADDRESS:**

CONSULTATION DATE (IF PROVIDED):

DATE OF FIRST PROCEDURE:

DATE OF PRE-SCHEDULED FOLLOW UP/ TOUCH UP VISIT:

**CLIENT SIGNATURE: DATE:**

**\*\*DO NOT WRITE BELOW THIS LINE\*\***

**ADDITIONAL PROCEDURE NOTES**

PIGMENTS USED:

TOOL/NEEDLE:

CLIENTS NUMBING: ( ) EASY ( ) AVERAGE ( ) DIFFICULT ( ) VERY DIFFICULT

ANESTHETIC USED:

AFTER CARE: A+D OINTMENT GIVEN ( )

TECHNICIANS SIGNATURE: DATE: