



Hands Across Tennessee, LLC DBA The Spa of Cool Springs
539 Cool Springs Blvd * Suite 140 * Franklin, TN 37067 * (615) 771-0003

Facial Client Registration and Questionnaire

Please answer the following questions so that we can have a better understanding of your general health and concerns, thereby enabling us to more accurately analyze your aesthetic request and or the possible factors of your present Skin/Health condition.

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Business Phone _____

Fax Number _____ Email Address _____

Birthday _____ Age _____

How did you hear about us? _____

Are you presently using the following: Yes No

Retin A/ Renova

Glycolic Acid/Alpha Hydroxy Acid

Accutane

Vitamin C

Check either Yes or No to the following questions: Yes No

- Have you ever had an allergic reaction to any skin product or cosmetic?

If yes, Explain: _____

- Have you recently undergone a skin peel?

If yes, Explain: _____

- Do you have Hyperpigmentation (melasma/brown spots?)

If yes, Explain: _____

- Do you use sunscreen?

If yes, Explain: _____

- Do you subscribe or participate in outdoor activities

If yes, Explain: _____

- Do you have facial wrinkles and age lines?

If yes, Explain: _____

- Do you have acne?

If yes, Explain: _____

- Have you been diagnosed with hypertension?

If yes, Explain: _____

- Have you been diagnosed with diabetes?

If yes, Explain: _____

- Have you been diagnosed with any form of heart disease?

If yes, Explain: _____

- Are you allergic to iodine?

If yes, Explain: _____

- Do you have a history of epilepsy?

If yes, Explain: _____

- Do you have implants or a pacemaker?

If yes, Explain: _____

- What products do you currently use on your skin? _____

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- Are you presently under a physician care for any reason?
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Explain _____

If Yes, provide Physician's name, address and phone number. _____

Person to contact in case of emergency: _____

- Have you had any of the following? Yes No
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Cosmetic Surgery

If yes, Explain: _____

Laser Resurfacing

If yes, Explain: _____

Chemical Peels

If yes, Explain: _____

Check either Yes or No to the following questions: Yes No

Are you allergic to aspirin? _____

Any other allergies. List _____

Do you smoke? _____

Do you exercise? _____

Do you wear contacts? _____

Have you had skin treatments before? _____

If yes, Explain _____

Have you had any waxing or electrolysis in the last week? _____

Have you had permanent cosmetics done? _____

Explain _____

What is your ethnic background? _____

Are you pregnant? _____. If yes, how far along? _____

List all supplements you are currently taking (include vitamins). _____

How much water do you drink a day? _____

Do you have claustrophobia? _____

Please explain any other information I should know before beginning your treatment? _____

Describe the treatment you are requesting. _____

Explain your request for such treatment _____

I hereby authorize and consent for the aesthetician to perform Skin Care Treatments or Waxing. I hereby confirm I had a discussion with my aesthetician regarding treatment benefits and consequences. I understand results may vary with different skin types. I understand there is a possibility of side effects such as scarring as well as short term effects such as reddening, mild burning and temporary discoloration of the skin. These effects have been fully explained to me. Skin Care Treatments and/or Waxing may consist of multiple treatments given over several months. Occasionally, an additional treatment may be required in order to achieve optimal results. I understand the treatments may involve risks of complication or injury from both known and unknown causes and I freely assume these risks. Alternative means of treatment and their risks have been explained to me. I certify that I have read this entire Informed Consent and I understand and agree to the information provided. I certify that I am a competent adult of at least 18 years of age or that if I am a minor under the age of 18, I understand that the consent of my parent/legal guardian/person having legal custody will also be required before treatment. This informed consent is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors and assigns. I agree to all safety precautions and regulations during the treatment.

The following points have been discussed with me:

- The probability of success.
- The reasonably anticipated consequences.
- The most likely possible complications/risks involved with the proposed treatment and subsequent healing period including, but not limited to, infection, scarring, blistering and pigmentary changes.
- Photographs will be taken and may be used for educational purposes.
- The possible alternative treatments.
- The potential benefits of the proposed treatment.

ACKNOWLEDGMENT

I UNDERSTAND AND ACKNOWLEDGE THAT PAYMENTS FOR THE ABOVE TREATMENT(S) ARE NON-REFUNDABLE. BY MY SIGNATURE BELOW, I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THIS PERMISSION FORM FOR SKIN CARE AND WAXING TREATMENTS AND THE DISCLOSURES REFERRED TO HEREIN WERE MADE TO ME.

Signature – Client Guardian

Print Name/Relationship

Date

Signature – Witness

Print Name/Relationship

Date