IPL CONSULTATION AND LIABILITY DOCUMENTATION

Please note, during your initial consultation a test patch will be performed and a treatment may only commence one week after, in order to assess the reaction.

Name ..... **Date:** .....

Address: ..... Date of Birth: .....

Suburb: ..... Postcode: .....

Home Phone: ..... Mobile: .....

Email Address:.....

How did you hear about us? .....

Contact in case of emergency:.....

Place a tick in the areas of concern:

- ☐ Entire face
- ☐ Forehead
- ☐ Between the eyebrows
- ☐ Upper lip
- ☐ Chin
- ☐ Nose
- ☐ Cheeks
- ☐ Side of face
- ☐ Ears
- ☐ Neck
- ☐ Shoulders
- ☐ Chest
- ☐ Arms
- ☐ Tummy
- ☐ Underarms
- ☐ Areola
- ☐ Hands
- ☐ Abdomen
- ☐ Back
- ☐ Buttocks
- ☐ Bikini full
- ☐ Bikini half
- ☐ Feet
- ☐ Toes only
- ☐ Other, please note:

Hair Removal Treatment Only:

What is your current method of hair removal?

- ☐ Tweezing
- ☐ Depilatory Cream
- ☐ Shaving
- ☐ Electrolysis
- ☐ Waxing - date of last wax: .....
- ☐ Other, please note: .....

When did you notice the hair appearing?

- ☐ During puberty
- ☐ At menopause
- ☐ During/after pregnancy
- ☐ 1-2 years ago
- ☐ 2-5 years ago
- ☐ Over 5 years ago
- ☐ Is there a family history of excess hair?

  Yes / No

How frequently are you removing the hair? ☐ Daily ☐ Weekly ☐ Monthly

MEDICAL QUESTIONAIRE

	YES	NO
Are you currently under a doctor's / healthcare practitioner's care?	☐	☐

If yes, for what?

.....

Have you had significant sun exposure in the last 4 to 6 weeks?	☐	☐
Do you use sun beds, spray-tanning products or tinted moisturisers?	☐	☐
Do you have tattoos or permanent makeup in areas to be treated?	☐	☐
Are you currently pregnant or trying to conceive?	☐	☐

Have you ever experienced or been treated with / for the following:

Contra Indications	YES	NO		YES	NO
Epilepsy	☐	☐	Photosensitising Drugs	☐	☐
Keloid	☐	☐	Warfarin	☐	☐
Pacemaker	☐	☐	Roacutane	☐	☐
Skin Cancer	☐	☐	Cancer - current treatment	☐	☐
Heart condition	☐	☐			

Special Precautions:

Cold sores	☐	☐	Skin Disorder	☐	☐
Diabetes	☐	☐	Aspirin	☐	☐
Metal Implant/piercings	☐	☐	Medical Condition	☐	☐
Anti Coagulants	☐	☐	Allergies	☐	☐
Hormonal Condition	☐	☐	Skin Pigment on treatment site	☐	☐
Hormonal Medication	☐	☐	Anti-inflammatory Drugs	☐	☐
Lack of Sensation	☐	☐	Lack of Temperature Awareness	☐	☐

If yes to any of the above, please explain and include dates / details:

.....

.....

.....

Have you ever had any of the following:

	YES	NO		YES	NO
Chemical Peel	☐	☐	Botox / Injectables	☐	☐
Micro Dermabrasion	☐	☐	Resurfacing or factional Laser	☐	☐
Implants	☐	☐	Surgery in treatment area	☐	☐
IPL	☐	☐	Dermal Rolling	☐	☐

If yes to any of the above, please explain and include dates / details:

.....

.....

What Skincare products are you currently using?

.....

.....

Please list all PAST medications used in the last 3 months:

Medication For Duration

.....

.....

Please list all CURRENT medications:

Medication For Duration

.....

.....

Please list all CURRENT vitamin supplements, herbal remedies:

Medication For Duration

.....

.....

Client Consultation Form - Informed Consent

I understand that the Village Beauty Intensive Pulsed Light technology is used for removal of unwanted hair, that clinical results may differ in different people, according to health, lifestyle, skin and hair type as well as the medication condition of the client. The treatment will not cure any medical conditions causing unwanted hair. The purpose of the treatment is to achieve cosmetic improvement, by reducing hair growth.

I _____ duly authorize staff of Village Beauty and other specially trained associate technicians to perform hair removal using Pulsed Light methods.

I have been advised of the following possible risks of Laser and Pulsed Light treatments: **Client Initial**

1	The treatment may not produce permanent hair removal. Due to the nature of this treatment an exact result cannot be predicted and I acknowledge that no guarantees have been made ot me as to the results that may be obtained	
2	Possible side effects of the area treated can include mild discomfort, swelling and colour changes may develop	
3	Colour changes, such as hyperpigmentation (brown/red discolouration) or hypopigmentation (skin lightening) may occur in treated skin. This may take several/many months to return to normal	
4	Blistering and mild crusting of the skin may occur. Scarring is a rare possibility but it has occured in less than 1% of the treatment population.	
5	**Skin must be protected from any UV exposure (including the sun and sunbeds) for six weeks before and after treatment. Unprotected sun exposure in the weeks pre and post treatment may product hyper / hypo pigmentation.**	
6	A rare side effect is the possibility of a paradoxical increase in fine hair growth surrounding the treatment site.	
7	Client must use proper eye protection as recommended by the laser or Pulsed Light Manufacturer	
8	I have received written client information / after care information	
9	I agree to follow aftercare recommendations as directed by this client	
10	My questions regarding this procedure have been answered to my satisfaction. I accept all risks of treatment.	
11	I consent to photographs for the purpose of monitoring response to therapy	
12	I understand that the treatment involves a series of treatments and that the fee structure is payable per treatment as it has been full explained to me	
13	I have read and understand the treatment. Should any products or the treatment or the machine functioning cause any allergic reaction, damage, pain of any degree whatsoever, I cannot hold any employee or the entity Village Beauty or owners liable.	

Client Signature: ..... **Date: .....**

Guardian Signature: ..... **Date: .....**

Technician Signature: ..... **Date: .....**

By signing below I confirm that any changes to medical history or medications have been notified. All information on this form is current and up to date.
I understand that Village Beauty are unable to treat clients who have had unprotected sun exposure - or use of tanning beds or creams in the areas to be treated within the last four weeks. Protected sun exposure means the wearing of protective clothing or the daily use of a SPF 30+ or greater sunscren.
Should you neglect informing us of any other medications this could affect the results of the treatment. Please do not hesitate to contact us should ou have forgotten some information.

1st treatment Signature ..... Date: .....

2nd treatment Signature ..... Date: .....

3rd treatment Signature ..... Date: .....

4th treatment Signature ..... Date: .....

5th treatment Signature ..... Date: .....

6th treatment Signature ..... Date: .....

7th treatment Signature ..... Date: .....

8th treatment Signature ..... Date: .....

9th treatment Signature ..... Date: .....

10th treatment Signature ..... Date: .....

11th treatment Signature ..... Date: .....

12th treatment Signature ..... Date: .....

13th treatment Signature ..... Date: .....

14th treatment Signature ..... Date: .....

CLIENT CONSULTATION FORM (Therapist to complete)

Name: ..... **Date:** .....

Health assessment & suitability for treatment checked	☐	Hyper / hypo pigmentation and other side effects explained	☐
Treatment process explained	☐	Sun issues explained	☐
Hair growth cycle explained	☐	Informed consent reviewed and signed	☐
Variability of results explained	☐	Home care recommendations explained	☐
Program - Series of treatments and maintenance sessions explained			☐

Concerns: .....

.....

Quote: .....

Test Patches **Date performed:** .....

Residual Tan		Hair Thickness		Blood vessel Thickness	

Area	Spot Size	Applicator/filter Type	J/cm²	No of shots	Operator Signature
Test 1					
Test 2					
Test 3					

Comments immediately following test spots: .....

Follow up Assesment of test patches **Date:** .....

Test 1 .....

Test 2 .....

Test 3 .....

Date:

Photo:		Hair	
Shots:		Initial	

Date:

Photo:		Hair	
Shots:		Initial	

Date:

Photo:		Hair	
Shots:		Initial	

Date:

Photo:		Hair	
Shots:		Initial	

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Shots:		Initial	

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Shots:		Initial	

Date:

Photo:		Hair	
Shots:		Initial	