Client Information

DATE:_____

RETURNING CLIENTS | Any changes since last visit? ❍ **No** ❍ **Yes** *If yes please indicate changes on form.*

CLIENT NAME: _____ **GENDER:** ❍ **M** ❍ **F** **DOB** _____

ADDRESS _____ **CITY**_____ **STATE**_____ **ZIP** _____

PREFERRED CONTACT NUMBER _____**EMAIL** _____

May we leave a message if we do not reach you personally? ❍ No ❍ Yes

WHAT ARE YOUR TOP 3 SKINCARE CONCERNS:

1. _____

2. _____

3. _____

MEDICAL HISTORY: Pregnant? ❍ No ❍ Yes Breastfeeding? ❍ No ❍ Yes

Do you smoke? ❍ No ❍ Yes

Health Conditions: _____

Past Surgeries: _____

Have you ever been diagnosed with Cancer? ❍ No ❍ Yes (last treatment date)_____

Current Medications: _____

Prescription Topicals: _____

Allergies (include aspirin & iodine): _____

PREVIOUS TREATMENTS:

Facials	❍ No ❍ Yes	Last treatment: _____	Any complications?_____
Microdermabrasion	❍No ❍Yes	Last treatment: _____	Any complications?_____
Chemical Peels	❍ No ❍ Yes	Last treatment: _____	Any complications?_____
Waxing	❍ No ❍ Yes	Last treatment: _____	Any complications?_____
Tanning	❍ No ❍ Yes	Last treatment: _____	Any complications?_____
Laser Therapy	❍ No ❍ Yes	Last treatment: _____	Any complications?_____
Massage	❍ No ❍ Yes	Last treatment: _____	Any complications?_____

SKIN CONDITIONS: *(please check all the items below that pertain to you)*

❍ Skin Infection	❍ Herpes (cold sores)	❍ Keloids/Excessive Scarring	❍ Sun Sensitivity
❍ Skin Cancer	❍ Poor Healing	❍ Tattoos/Permanent Makeup	❍ Easy Bruising
❍ Eczema	❍ Psoriasis	❍ Lymph Nodes Removed	❍ Diabetes

SKINCARE: What type of skin do you feel you have? ❍ Dry ❍ Oily ❍ Normal ❍ Combination

What is your skin routine? *(Indicate any cleansers, toners, serums, moisturizers, masques, etc.)*

1._____ 4._____

2._____ 5._____

3._____ 6._____

Osmosis Treatment Consent

CLIENT NAME: _____ **DATE:** _____

PLEASE INITIAL:

_____ I agree that the nature and purpose of the treatment has been explained to me and any questions I have regarding the treatment have been explained to my satisfaction.

_____ I understand that with any treatment certain risks are involved and that any complications from known or unknown causes could occur.

_____ I understand that possible side effects include, but are not limited to: mild to moderate redness, mild to moderate peeling or flaking, stinging, dry skin, tenderness, pimples, cold sores or allergic reactions. Most side effects are temporary and will dissipate within 3-7 days.

_____ I do not have active cold sores.

_____ I will call to inform my skincare professional of any complications or concerns I may have as soon as they occur.

_____ I understand that it is recommended prior to having a facial infusion to *not* have used Retin A for 72 hours, Accutane in 6 months or have waxed 24 hours prior to receiving treatment.

_____

CLIENT SIGNATURE PRINT NAME DATE

TECHNICIAN NOTES:

Treatment Receiving Today (check one):

- ❍ Medi-Facial
- ❍ Facial Infusion
- ❍ Medi-Infusion
- ❍ Holistic Calming Facial
- ❍ Holistic Stimulating Facial
- ❍ *RevitaPen Pro Facial*
- ❍ Other _____
- _____

Notes:

I have reviewed the treatment and post care instructions to the client stated above and answered any questions.

_____

TECHNICIAN SIGNATURE DATE

Beyond Lavender
9336 Team Ranch Road, Suite 204
Fort Worth, TX 76126
817-683-4138

Reschedule/Cancellation & Late Appointment Policy

Your appointment time has been reserved exclusively for you. As a courtesy, a 48-hour email reminder and a 24-text reminder will be sent to you.

24 HOUR NOTICE is required to reschedule or cancel your appointment.

Reschedules/Cancellations with less than **24 HOURS NOTICE** or a no show for an appointment will result in full charge to your credit card on file.

Regrettable, late arrival will affect your appointment time. The appointment will end at your scheduled time and full fee will be charged. Thank you for your cooperation.

CREDIT CARD ON FILE REQUIRED:

I agree to the policies described above.

Signature_____ Date: _____

Client's Printed Name: _____

If services are for a minor, parent/guardian, please sign below.

Parent/Guardian Signature _____ Date: _____

Credit Card Info

[ ] Mastercard [ ] Visa [ ] Discover

Name on Card: _____

Number _____

Expiration Date: _____ Billing Zip Code: _____ CVS: _____