eXponentialBeauty Medispa
1147 S. Wabash Avenue, Suite 200 Chicago, Illinois 60605
312-585-7474(P) 312-585-5974 (F)

NEW CLIENT HISTORY

Date: _____

First Name: _____ Last Name: _____

Birth Date: _____ (mm/dd/yyyy) Occupation: _____

Address: _____

City: _____ State: _____ Zip code: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email (optional): _____

How did you hear about us? _____

What brings you to eXponentialBeauty? _____

Ethnic Background: _____

MEDICAL HISTORY

Do you have any chronic medical conditions which we should know about? ☐ Yes ☐No

If so, please list:_____

Do you have any allergies to latex, medications, herbal or natural supplements? ☐ Yes ☐No

If so, please list:_____

Do you have, or have you had, any changes in medical history recently? ☐ Yes ☐No

Please list any and all current/past surgeries or surgical procedures._____

Have you taken Accutane within the past year? ☐ Yes ☐No

Are you on any anticoagulants, daily Aspirin, Motrin, or Advil? ☐ Yes ☐No

Are you a smoker? ☐ Yes ☐No

Do you have veneers on your teeth? ☐ Yes ☐No

Do you have a history of cold sores, fever blisters or herpes 1 or 2? ☐ Yes ☐No

If so, when was your last outbreak? _____ *the use of lasers and IPL can trigger an outbreak

Do you have a history of hypo/hyper-pigmentation? ☐ Yes ☐No

Do you have a history of keloid scarring ☐ Yes ☐No

Have you ever been treated with a laser, microdermabrasion, chemical peel, or injection? ☐ Yes ☐No

If so, please list: _____

What skin products are you currently using? _____

Are you happy with your skin care products? ☐ Yes ☐No

Do you or have you used any topical medications or creams such as
Retin-A, Renova, Tazorac, Differin, Obagi, or any others? ☐ Yes ☐No

If so, please list:_____

Do you have permanent makeup or tattoos? ☐ Yes ☐No

If so, please list: _____ When was last use? _____

WOMEN ONLY:

Are you or could you be pregnant? ☐ Yes ☐No

Are you currently breast-feeding? ☐ Yes ☐No

Are you menstrual cycles normal? ☐ Yes ☐No

Please tell us about your skin (check all that apply):

☐ Normal	☐ Acne	☐ Hyper-pigmentation
☐ Dry	☐ Large Pores	☐ Hypo-pigmentation
☐ Oily	☐ Melasma	☐ Broken Capillaries

Natural Hair Color: _____ Eye Color: _____

Have you had any recent sun exposure in the past 4-6 weeks,
including tanning beds, bronzing creams or spray-on tans? ☐ Yes ☐No

If so, please specify: _____

What are your skincare goals? _____

Additional information you would like your technician to know: _____

_____

Client Signature: _____ Date: _____

Witness: _____ Date: _____

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SKIN TYPING WORKSHEET

Patient Name: _____ Date: _____

Skin Score		0	1	2	3	4
	What is your eye color?	Light Blue or Grey	Blue or Green	Hazel or Light Brown	Dark Brown	Brownish Black
	What is your natural hair color?	Red, Sandy Red	Blonde	Dark Blonde, Chestnut, Brown	Dark Brown	Black
	What is the color of your skin (unexposed areas)?	Reddish	Very Pale	Pale with Beige Tint	Light Brown	Dark Brown
	Do you have freckles on exposed areas?	Many	Several	Few	Incidental	None
	What happens when you stay in the sun too long?	Painful, redness, blistering and peeling	Blistering followed by peeling	Burns, sometimes followed by peeling	Rarely burn	Never burn
	To what degree do you turn brown?	Hardly or not at all	Light tan	Reasonable tan	Tan very easily	Turn dark brown quickly
	How does your face respond to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never has problems in the sun
	When did you last expose yourself to the sun, tanning beds or self-tanning creams?	More than 3 months ago	2-3 months	1-2 months	Less than 1 month ago	Less than 2 weeks ago
	How often is the area that you want to have treated exposed to the sun?	Never	Hardly Ever	Sometimes	Often	Always
TOTAL	Score / Skin Type 0-7 I 8-16 II 17-25 III 26-30 IV Over 30 V-VI					

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CLIENT RIGHTS AND RESPONSIBILITIES

We are committed to serving you with compassion, care, and respect. As one of our valued clients you are entitled to the following:

You have the right:

- To be treated with respect and dignity.
- To know the names and professional status of the person(s) serving you.
- To privacy and confidentiality.
- To receive accurate information about your health-related concerns.
- To know the effectiveness and potential side-effects of all forms of treatment.
- To participate in choosing the form of treatment best suited to your skin.
- To receive education and counseling about treatments.
- To review your medical record with your clinician.
- To amend your records.
- To receive any information about potential services or related services.

You have the responsibility:

- To seek medical attention promptly, and to provide useful feedback.
- To be honest about your medical history.
- To be honest about your sun exposure.
- To ask questions about anything you do not understand.
- To follow health advice and instructions.
- To report any significant changes in your health.
- To respect clinic policies.
- To show up to appointments or cancel 48 hours in advance.

I authorize eXponentialBeauty to perform the treatment or procedures recommended. I acknowledge no guarantee; either expressed or implied has been made to me regarding the outcome of any treatment or process.

I fully understand that it is impossible for anyone to make a guarantee regarding the outcome of any medical treatments or procedures.

I understand I am financially responsible for all procedures due when services are rendered, and for any appointment I fail to attend without 48 hours notice.

I authorize the release of information to a licensed physician of the facility's choosing for the purpose of professional interpretation and establishment of their recommendations.

Client Signature: _____ Date: _____

Reviewed by: _____ Date: _____

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CANCELLATION POLICY

SPA APPOINTMENTS

We request that you give us ample notice if you need to cancel or reschedule your appointment. Ideally 24 - 48 hours prior.

We do require a credit card to be kept on file for spa appointments, and if you no show your scheduled appointment your card will be charged a $50 No Show Fee.

I agree and understand eXponentialBeauty's cancellation policy.

Print Name: _____

Client Signature: _____ Date: _____

Witness: _____ Date: _____

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CONSENT FOR PULSED LIGHT/LASER TREATMENTS

I give my consent and authorization to National Laser Institute to treat me with cosmetic laser and/or pulsed light modalities. This includes, but is not limited to, photofacials, fractional laser skin resurfacing, laser and intense pulse light hair removal, light-based treatment of pigmented or vascular lesions, intense pulse light acne reduction, and laser tattoo removal.

I understand that these procedures are purely elective, that the results may vary with each individual, no guarantee can be provided in regards to the outcome of medical procedures such as these, and multiple treatments may be necessary to achieve maximum results.

I acknowledge and understand that:

- Serious complications are rare, but possible.
- Common side effects include temporary redness and mild "sunburn" like effects that may last anywhere from a few hours to 3-4 days.
- Pigment changes, including hypo-pigmentation (lightening of skin) or hyper-pigmentation (darkening of skin) lasting 1-6 months or longer, may occur.
- Freckles may temporarily or permanently disappear in treated areas.
- Other potential risks include crusting, itching, pain, bruising, burns, infection, scabbing, scarring, swelling, and failure to achieve the desired result.
- Laser and intense pulse light treatments can cause eye injury and protective eyewear must be worn during the all treatments.
- I understand that sun or tanning lamp exposure and not adhering to the post-care instructions provided by National Laser Institute may increase my chances of complications.

I consent to photographs being taken for use in the follow areas: evaluation of treatment effectiveness, medical education and training, marketing, media stories, advertising and other sales purposes. No photographs revealing my identity will be used without my written consent. If my identity is not revealed, these photographs may be used and displayed publically without my permission.

I acknowledge that pre- and post-treatment instructions have been discussed with me. The procedure as well as potential benefits and risks have been explained to my satisfaction. I have had all my questions answered. I freely consent to the proposed treatments.

Client Signature: _____ Date: _____

Print Name: _____ Date: _____

Witness Signature: _____ Date: _____

Print Name: _____ Date: _____

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PRE AND POST CARE FOR LASER HAIR REDUCTION AND PHOTOFACIALS

PRE:

- Avoid the sun for 4-6 weeks before and after the treatment
- Avoid electrolysis, plucking, and/or waxing for 6 weeks prior to treatment
- If you have a history of herpes, prophylactic antiviral therapy must be started the day before treatment and continued one week after treatment.
- The use of tanning creams, tanning beds, or bronzers must be discontinued before and during treatments.

POST:

- Immediately after treatment there may be erythema (redness) and edema (swelling) at the treatment site. This usually lasts 2 hours or longer. The erythema may last up to 10 days. The treatment area may feel like a sunburn for a few hours after the treatment, but it will subside.
- Apply ice as needed.
- Hydrocortisone may be used for 3 - 5 days post treatment.
- No heat, such as saunas, steam rooms, Jacuzzis, extremely hot showers, or strenuous activities. No prolonged heat for a minimum of 48 hours post treatment.
- Avoid sun exposure to avoid hypo-pigmentation and hyper-pigmentation.
- Avoid picking or scratching the treated areas. Please do not use any hair removal products or similar treatments (i.e. electrolysis, plucking, and/or waxing). Those will disturb the hair follicle. Shaving is permitted.
- Up to 2 weeks post treatment you will notice shedding of the treated hair. This is not new growth. You can clean and remove the hair by washing or wiping the area with a wet cloth.
- Treat your skin gently for at least 24 hours after your treatment.

I have read and understand the pre and post treatment instructions.

Client Signature: _____ Date: _____

Print Name: _____ Date: _____

Provider Signature: _____ Date: _____

Print Name: _____ Date: _____

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LASER SCREENING

Name: _____ Date: _____

If you answer yes to any of these questions you may not be able to participate in certain laser treatments at this time.

Are you pregnant? ☐ Yes ☐No
Do you or have you had skin cancer? ☐ Yes ☐No
If so, where did you have skin cancer? Area(s) _____
Is it in the area you are wanting to treat with Fractional? ☐ Yes ☐No
When was your last dermatologist check? Date:_____
Do you experience Keloid scarring or any other textual skin changes after procedures? ☐ Yes ☐No
Are you currently on any topical or oral antibiotic acne medication? ☐ Yes ☐No
If so, what are you using? Medication(s): _____
When was your last dose? Date(s): _____
Have you recently been on Accutane? ☐ Yes ☐No
What is you ethnic background (i.e. Italian, French, Hispanic, African American, etc.)?_____

The following are precautionary when participating in certain laser treatments.
Do you use exfoliating products? (i.e. Retin-A, Retinol, or Aggressive Scrubs) ☐ Yes ☐No
If so, when were they last used? _____
Do you have a cold, the flu, or any other sickness? ☐ Yes ☐No
Do you take corticosteroids? ☐ Yes ☐No
Do you have blood disorders? ☐ Yes ☐No
Do you use blood anticoagulants? ☐ Yes ☐No
Do you have Herpes in or around the treatment area? ☐ Yes ☐No
If so, you must take an antiviral for 2 days prior to treatment, day of treatment, and 2 days post treatment.
Do you have Diabetes or any other medical condition that will impair the healing process? ☐ Yes ☐No
Do you experience Vitiligo? ☐ Yes ☐No
Do you have Eczema or Psoriasis? ☐ Yes ☐No
Do you experience Allergic Dermatitis? ☐ Yes ☐No
Is your immune system compromised in any way? (i.e. HIV, Steroids or age) ☐ Yes ☐No
Do you have any collagen diseases such as Ehlers-Danlos or Scleroderma? ☐ Yes ☐No
Do you have any social engagements in the next 2 days? ☐ Yes ☐No
Do you currently have any dermal fillers in the treatment area? ☐ Yes ☐No

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BOTULINUM TOXIN TYPE A: BOTOX® COSMETIC & DYSPORT® CONSENT FORM

BOTOX® Cosmetic is indicated for the temporary improvement in the appearance of moderate to severe glabellar lines (lines between the eyebrows) associated with corrugator and/or procerus muscle activity in adult patients less than or equal to 65 years of age.

BOTOX® Cosmetic (onabotulinumtoxinA) for injection, is a sterile, vacuum-dried purified botulinum toxin type A, produced from fermentation of Hall strain Clostridium botulin um type A grown in a medium containing casein hydrolysate, glucose, and yeast extract, intended for intramuscular use. BOTOX® Cosmetic blocks neuromuscular transmission by binding to acceptor sites on motor nerve terminals, entering the nerve terminals, and inhibiting the release of acetylcholine. This inhibition occurs as the neurotoxin cleaves SNAP-25, a protein integral to the successful docking and release ofacetylcholine from vesicles situated within nerve endings. When injected intramuscularly at therapeutic doses, BOTOX® Cosmetic produces partial chemical denervation of the muscle resulting in a localized reduction in muscle activity.

Administration ofBOTOX® Cosmetic is not recommended during pregnancy. There are no adequate and well-controlled studies of BOTOX® Cosmetic in pregnant women. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when BOTOX® Cosmetic is administered to a nursing woman.

DYSPORT™ (abobotulinumtoxinA) is an acetylcholine release inhibitor and a neuromuscular blocking agent indicated for the temporary improvement in the appearance of moderate to severe glabellar lines associated with procerus and corrugator muscle activity in adult patients less than 65 years of age.

The effects of DYSPORT™ and all botulinum toxin products may spread from the area of injection to produce symptoms consistent with botulinum toxin effects. These symptoms have been reported hours to weeks after injection. Swallowing and breathing difficulties can be life threatening and there have been reports of death. The risk of symptoms is probably greatest in children treated for spasticity but symptoms can also occur in adults, particularly in those patients who have underlying conditions that would predispose them to these symptoms.

DYSPORT™ is contraindicated in patients with known hypersensitivity to any botulinum toxin preparation or to any of the components in the formulation. This product may contain trace amounts of cow's milk protein. Patients known to be allergic to cow's milk protein should not be treated with DYSPORT™.DYSPORT™ is contraindicated for use in patients with infection at the proposed injection site(s).

There are no adequate and well-controlled studies in pregnant women. DYSPORT™ should he used during pregnancy only if the potential benefit justifies the potential risk to the fetus. It is not known whether DYSPORT™ is excreted in human milk.

I authorize and direct eXponentialBeauty to perform the following procedure of Botox® Cosmetic and Dysport® injections on _____(patient name) for the treatment of (areas to be treated):

(continued on next page)

- ☐ Glabella (area between eyebrows) Initials: _____
- ☐ Forehead Initials: _____
- ☐ Crows Feet Initials: _____
- ☐ Other: _____ Initials: _____

Please initial the following:

_____ The details of the procedure have been explained to me in terms I understand.

_____ Alternative methods and their benefits and disadvantages have been explained to me.

_____ I understand that the FDA has only approved the cosmetic use of Botox® Cosmetic and Dysport® for frown lines between the brows. Any other cosmetic use is considered off label.

_____ I understand and accept the most likely risks and complications of Botox® Cosmetic and Dysport® injections.

Including but not limited to:

- ❖ Paralysis of a nearby muscle that could interfere with opening of eye(s).
- ❖ Local numbness
- ❖ Headache, nausea, or flu-like symptoms
- ❖ Swallowing, speech, or respiratory disorders
- ❖ Swelling, bruising, or redness at the injection site
- ❖ Disorientation and double vision
- ❖ Temporary asymmetrical appearance
- ❖ Abnormal or lack of facial expression
- ❖ Inability to smile when injected in the lower face
- ❖ Facial pain
- ❖ Product ineffectiveness

_____ I understand and accept that the long-terms effects of repeated use of Botox® Cosmetic and Dysport® injections are unknown. Possible risks and complications that have been identified, but are not limited to:

- ❖ Muscle Atrophy
- ❖ Nerve irritability
- ❖ Production of antibodies with unknown effect to general health

_____ I understand and accept the less common complications, including the remote risk of death or serious disability that exists with this procedure.

_____ I am aware that smoking during the pre and post-operative periods could increase chances of complications.

_____ I have informed the doctor or nurse of all my known allergies, including any allergies to latex.

(continued on next page)

_____ I have informed the doctor or nurse of all medications I am currently taking including remedies, herbal therapies, and any other.

_____ I have been advised whether I should take any or all of the medications on the days surrounding

_____ I am aware and accept that no guarantees regarding the result of this procedure have been made or implied.

_____ I understand that if I receive my treatment in a training environment, the medical professional performing this treatment is being supervised by an experienced injector, (not necessary to initial for private appointments).

_____ I understand that the medical professional supervising my injector will recommend the amount of product that he/she believes is appropriate for the results that I desire. If I choose not to accept that recommendation, I understand that I may not achieve the desired result and any further treatments to achieve the desired result will require full payment.

_____ Prices are subject to change. The pricing I receive during this treatment is only for today's treatment. Any additional treatments, products or services will be billed at rates in effect at time of the additional treatments.

_____ I have been informed of what to expect post-treatment, including but not limited to procedures I can do if I wish to maintain the appearance that this procedure provides me.

_____ I am not currently pregnant or nursing, and I understand that should I become pregnant while using Botox® Cosmetic and Dysport® there are risks, including fetal malfunction.

_____ If pre and post-treatment photos and/or video are taken of the treatment for record purposes, 1 understand that these photos will be the property of the attending doctor or nurse.

_____ The doctor and/ or nurse has answered all my questions regarding this procedure.

_____ I have been advised to seek immediate medical attention if swallowing, speech, or respiratory disorders arise.

_____ I certify that I have read and understand this agreement and that all spaces for initials were filled in PRIOR to my signature.

Patient Signature:_____ Date: _____

_____ I certify that I have explained the nature, purpose, benefits, risks, complications, and alternatives of the proposed procedure to the patient. I have answered fully, and I believe that the patient fully understands what I have explained.

Doctor or Nurse Signature:_____ Date: _____