CLIENT INTAKE FORM

Name ______________________________

Address ______________________________

Email ______________________________

Date ______________

Emergency contact ______________________________

Phone ______________________________

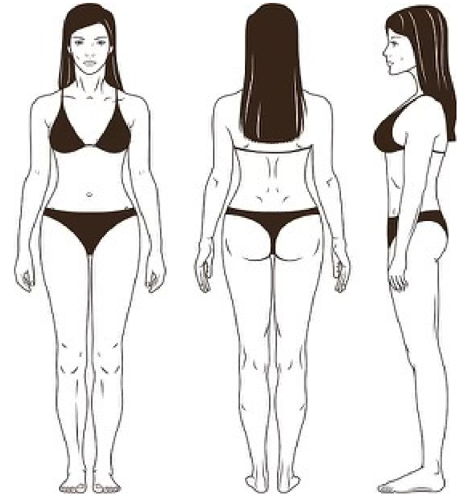
Practitioner ______________________________

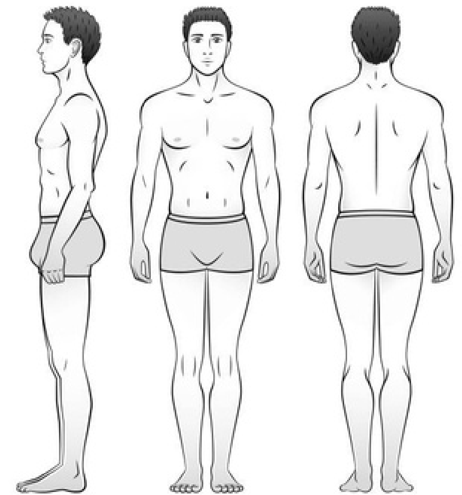
How did you learn about us? ______________________________

Which treatments are you interested in getting/learning more about?

- Body Contouring
- Fat Reduction
- Cellulite Reduction
- Laser Hair Removal
- Laser Skin Rejuvenation
- Jet Plasma
- Skin Tightening
- Maderotherapy
- Lymphatic Drainage Massage
- Brazilian Sculpting Massage

Areas Of Focus:





Fitzpatrick Scale & Skin Types

SKIN TYPE	TYPE 1	TYPE 2	TYPE 3	TYPE 4	TYPE 5	TYPE 6
Skin Color	Light	Light	Medium	Medium / Dark	Dark	Black
Hair Color	Red	Blond	Brown	Brown / Black	Black	Black
Eye Color	Green	Blue	Brown	Brown / Black	Black	Black

If applicable, please add any additional information in the notes portion below

- ☐ Abnormal wound healing
- ☐ Acute Pain
- ☐ Aging Skin (lines/wrinkles/laxity)
- ☐ Allergies
- ☐ Anemic/Iron Deficient
- ☐ Arthritis
- ☐ Autoimmune Disorder **
- ☐ Blistering Sunburns
- ☐ Blood Clots/Thrombosis
- ☐ Bruise Easily
- ☐ Cancer/Chemotherapy
- ☐ Chronic Pains
- ☐ Cold/Flu/Noro Virus
- ☐ Cosmetic Product Reaction
- ☐ Dark Under-Eye Circles
- ☐ Diabetes Insulin Dependent
- ☐ Dry Skin
- ☐ Fever Within 24hrs
- ☐ Freckles
- ☐ Headaches/Migraines
- ☐ Hearing Aid
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Herpes Simplex (Cold Sores)
- ☐ High or Low Blood Pressure
- ☐ HIV/Aids
- ☐ Hyperpigmentation (age spots)
- ☐ Hypoglycaemia
- ☐ Hypopigmentation (white spots)
- ☐ IUD/Metal Implants
- ☐ Keratosis Pilaris (skin bumps)
- ☐ kidney or Liver Disorders
- ☐ Latex Sensitivity/Allergy
- ☐ Lupus
- ☐ Melasma
- ☐ Neck Injury
- ☐ Oedema (swelling)
- ☐ Open Wounds
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Photosensitivity To Sun
- ☐ Peri/Menopause
- ☐ Pms/Menstruation
- ☐ Pregnant / Nursing
- ☐ Psoriasis
- ☐ Salicylic/Aspirin Allergy
- ☐ Sensory Issues
- ☐ Recent Surgery
- ☐ Rosacea
- ☐ TMJ
- ☐ Tumours/Growths/Cysts
- ☐ Scarring (keloid, or flat)
- ☐ Seizures/Stroke
- ☐ Severe Headaches/Migraine
- ☐ Sinus Congestion
- ☐ Sports Injury
- ☐ Hyper/Hypo Thyroid
- ☐ UTI/ Kidney Infection
- ☐ Varicose Veins/Spider Veins
- ☐ Wear Contracts

Additional Information

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Please list all medication, including hormonal birth control:

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PLEASE READ CAREFULLY AND INITIAL / SIGN WHERE INDICATED.

Ensure all points below have been discussed with the technician. You are signing to state that you understand and accept these terms.

1. I acknowledge that any information contributed by me is true, to the best of my knowledge and that the present condition of the area that has been, or will be treated is stated on this record. I fully understand that Julie A Harper/The Kürve Lounge/Kürvz By Jules provides beauty services; There is no medical treatment involved. Body Contouring/Laser/Jet Plasma/LDM Treatment is an art - not an exact science - and cannot guarantee an exact result due to skin elasticity, and individual, which includes client's health, genetics, lifestyle factors and following proper after care. (______)

2. I understand that Body Contouring/Laser/Jet Plasma/LDM requires a minimum of 3 suggested sessions for best results, and that I may be required to return for additional treatments before the overall procedure is deemed complete. The payment for any additional work, (if applicable), will be agreed prior to the treatment commencing. Depending upon treatment/area of treatment, additional treatments cannot be performed until 6-8 weeks after 8 sessions same area to allow sufficient healing time. (_______)

3. I realize that with any beauty service there may be certain risks, which must be understood I will be fully responsible for any and all results, which may arise from these beauty services. I do hereby agree to hold Julie Harper/The Kürve Lounge/Kürvz By Jules, their affiliates and employees/students free from any and all claims or suits for damage, for injuries or complications resulting from any beauty services provided by Julie A Harper/The Kürve Lounge/Kürvz By Jules. I understand that any revision work performed may result in loss or gain of natural skin pigment. (______)

4. The skin type of every client is different and although Jet is safe for all Fitzpatrick, it is important you follow our aftercare instructions. Additional sessions may be advised, after the healing process is complete. (_______)

5. I understand that taking before and after photographs of the said procedures is a requirement of such procedure. (______) I grant permission for the use of the photographs, or electronic media images as identified, in any presentation of all kinds. (_______)

6. I have received pre and post procedure instructions and will strictly adhere to them. I understand that my failure to do so may jeopardize my chances for a successful outcome. (________)

7. I understand the importance of my accurate and complete medical history. I understand that withholding any medical information may be detrimental to my health and safety during and after the procedure. I understand that if there is any change in my medical history, it is my responsibility to inform the technician/practitioner. (_______)

8. I am aware that any skin altering procedures such as Laser treatments, plastic surgery, implants, injectables and weight gain/loss may alter the treatments's look. (_______)

I, (_______________________), agree with all points listed and discussed, and wish to proceed as recorded with Julie Harper/The Kürve Lounge/Kürvz By Jules. I participated fully in the decision for the selected area or areas intended for my Body Contouring/Laser/Jet Plasma/LDM Treatment. I certify I have read and initialed the above paragraphs. I have had it explained to my understanding therefore I consent to this procedure. I accept full responsibility for the decision to receive this treatment and do not hold Julie A Harper/The Kürve Lounge/Kürvz By Jules responsible for any adverse reaction.

Client's Full Name (PRINTED):____

Client Signature:____

Date(M/DM):______________________

Practitioner:____