Sonata Spa **Confidential Case History # ____________**

Name____ Birth Date______________________

Address____City_______________________State___________Zip__________

Occupation_____________________________________ Drivers License#____

Home Phone______________________Cell/Text Phone____________________e-mail: ______________________________

How were you Referred? ____Person__________Person's Name_______Yellow pgs____Other______________________

Is your family aware that you are receiving treatment? ____Yes____No Emergency Contact ____________________________

Desired Treatment Areas

Facial/Head Area			Body Areas			
Upper/ Lower Lip	Sides of Face	Ears/ Nose	Arms ,Underarms	Breasts/Chest	Bikini Line	Feet/Toes
Chin /Cheeks	Hairline	Eyebrows	Abdomen	Hands/Fingers	Legs/Thighs	Back /Shoulders
Other:		Nape/ Neck				

Age on onset _____________Abrupt _____________Slow______________

Do you have any female blood relatives with excessive hair? If yes, who: ____

Are you currently under a physician's care? YES [ ] NO [ ] GYN [ ] DERMATALOGIST [ ] FAMILY [ ]

Physician's name and address____

Medical History

	YES	NO
Acne	[ ]	[ ]
Allergies	[ ]	[ ]
Canker sores	[ ]	[ ]
Contact Lenses	[ ]	[ ]
Cold Sores/Herpes	[ ]	[ ]
Cancer	[ ]	[ ]
Dermatitis	[ ]	[ ]
Diabetes	[ ]	[ ]
Hepatitis	[ ]	[ ]
Heart Condition	[ ]	[ ]
Pace Maker	[ ]	[ ]
Seizures	[ ]	[ ]
Metal Pins in Body	[ ]	[ ]
Surgery	[ ]	[ ]

	YES	NO
High Blood Pressure	[ ]	[ ]
Hemophilia	[ ]	[ ]
H.I.V. Tested	[ ]	[ ]
Keloid Scars	[ ]	[ ]
Moles	[ ]	[ ]
Warts	[ ]	[ ]
Females only condition:		
Menopause(current)	[ ]	[ ]
Post Menopause	[ ]	[ ]
Pregnant	[ ]	[ ]
Hysterectomy	[ ]	[ ]
Hormonal Imbalance	[ ]	[ ]
Irregular Periods	[ ]	[ ]
I.U.D.	[ ]	[ ]

Allergies/Sensitivities	**YES**	**NO**
Topical- Local	[ ]	[ ]
Alcohol	[ ]	[ ]
Aloe Vera	[ ]	[ ]
Anesthetics	[ ]	[ ]
Cosmetics	[ ]	[ ]
Sea Breeze	[ ]	[ ]
Latex Gloves/Powder	[ ]	[ ]
Food	[ ]	[ ]
Sun	[ ]	[ ]
Soaps	[ ]	[ ]
Other:		

Current Medications		**Type & Dosage**
Birth Control Pills	[ ]	
Cortisone	[ ]	
Hormones	[ ]	
Dilantin	[ ]	
Minoxidil	[ ]	
Other:		

Skin Care History

Current Skin Treatment	**Yes**	**No**	**Application**
Accutane	[ ]	[ ]	___________________________
Glycolic Topical/Peel	[ ]	[ ]	___________________________
Retin-A/Renova	[ ]	[ ]	___________________________
Botox/Other injections	[ ]	[ ]	___________________________
Facials	[ ]	[ ]	___________________________
Microdermabrasion	[ ]	[ ]	___________________________
Artificial Tanning	[ ]	[ ]	___________________________
Other ____			

Current Skin Care Products Brand Name /Routine

Cleanser ____________________ Morning ________Evening________

Toner_______________________ Morning ________Evening________

Moisturizer __________________Morning ________Evening________

Scrub _______________________Daily ___________Weekly________

Other____

____

Current method of removing hair: ___Shaving ___ Depilatory ___ Cutting ___ Bleaching ___Tweezing ___Waxing ___Laser

Other: ___________ Area(s):_________________________Frequency:_______________________Last used: ________________

Do you have any unusual skin condition? _______________**Do you have healing problems? IF yes, explain** ________________

Previous Electrolysis Treatments: None ___Blend ___ Galvanic ___ Thermolysis ___ Unknown___ Date started: _____________

Previous Electrologist _____________________ **Area treated and treatment schedule:** ___________________________________

Describe any manifestation of prior treatment on skin? ____

If you had Laser Hair Removal, when, what area and how many treatments were:____

What are your expectations of Electrolysis Treatment? ____

Signature____ **Date** _______________________________________

Informed Consent

_____I acknowledge that all information contributed by me is accurate to the best of my knowledge, and that the present condition of the areas to be treated is as stated on this record.

_____ I have been advised of the post-treatment healing process, possible risks related to treatment: redness, bruising, swelling, scabbing, scarring, infection of the skin.

_____I have read and understand the "Client Information & Aftercare Instructions" brochure given to me today and agree to follow all aftercare instructions and to notify the Electrologist of any difficulty in healing.

_____I understand that repeated treatments are necessary for permanent results and agree to follow my treatment plan:____

_____If I am unable to follow my treatment plan I will notify my Electrologist in order to modify or postpone my treatments.

_____If I do not, my treatment will be terminated and may result in future refusal.

_____I will give my Electrologist 48 hours notice in case I am unable to keep my appointment. If I do not, I will be charged for the time I reserved.

_____I agree to pay all fees associated with returned check, terminated debit, credit payment and will prepay my future visits by cash only.

Signature:____Date:_____________

Recommendations/Notes:

Option:

By signing this option section, I agree to release my "Before" and "After" pictures to be used for ____________________ marketing purposes. I understand there is no monetary payment offered for this. Pictures will be without names and only show the treated area.

Signature:________________________________ Print: ______________________________

Date: ____________________________________ Technician:__________________________