Electrolysis BEAUTY LOUNGE
we want your unwanted hair

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Client Health History Assessment

Client Number:
electrolysis office use only

Primary Information

Today's Date: MM / DD / YYYY   Date of Birth: MM / DD / YYYY

Legal First Name: ______ Middle Initial: ______ Legal Last Name: ______

Preferred Name: ______ Gender Identified as: ______ Prounouns: She/Her He/Him They/Them

Street Address: ______ City: ______ State: ______ Zipcode: ______

Phone: home /mobile ( ) ______ Email: ______

Hair Removal Information

Areas you are considering for treatment? {select all that apply}

Head: Lip / Mustache Chin Beard Cheeks/Jawline Eyebrows Ears {outside} Sideburns Hairline Neck

Body: Armpits Breast / Chest Navel / Happy Trail Bikini / Groin Anus Penis Shaft Upper Back Lower Back

Limbs: Shoulders Upper Arms Lower Arms Hands Fingers Outer Thighs Inner Thighs Lower Legs Feet Toes

Other: ______

Hair Removal Methods

What hair removal methods do you most frequently use? {select all that apply}

Shaving Waxing Sugaring Tweezing Creams Laser Threading Other: ______

Have you ever had electrolysis before? yes / no Date of last treatment: ______

Modality: {select all that apply} Thermolysis Blend Galvanic Not Sure

Have you ever had a negative effect from a hair removal method? yes / no

Please Explain: ______

Health Information

List All Medications & Vitamins You are Currently Taking:

Name	Purpose	Name	Purpose

List All Allergies:

Name	Comments	Name	Comments

Health Conditions Present or Past: {select all that apply}

Acne Body Piercings Beathing Problems Cancer Cardiovascular Disease Clotting Issues Cold Sores COPD Covid-19

Diabetes Dizziness / Fainting Heart Attack Healing Issues Hepatitus Herpes High Blood Pressure HIV Infertility

Metal Implants Keloids Kidney Disease Pacemaker Piercings PCOS TB Thyroid Disease Skin Tags Stroke Warts

Other: ______

Client Health History Assessment

Are you pregnant: yes / no **Do you get your period:** yes / no **If yes, is it regular:** yes / no

Have you traveled outside of the country in the last 30 days: yes / no **Where:** ______

Have you had any major surgeries? yes / no **Specify:** ______

Are you preparring for sex reassignment surgery? yes / no **Planned Date of Surgery:** MM / DD / YYYY

Other Information

How did you hear about us? Website Facebook Instagram Pinterest Google Referral ... who? ______

Other: ______

Media release

Does Electrolysis Beauty Lounge have permission to document your hair removal process through your story, pictures and or videos and use them in its print and/or digital publications? **Photographs:** yes / no **Videos:** yes / no

If you circled yes above read the following & initial below. If no, continue to 'Client Acknowledgement Section'

By circling yes above, you grant permission to Electrolysis Beauty Lounge, LLC. to post my and/or my child's electrolysis hair removal journey/story in the media formats circled and initaled above, hereinafter referred to as "Materials," on the Electrolysis Beauty Lounge website {www.electrolysisbeautylounge.com}, Instagram account {@electrolysisbeautylounge}, Twitter account {@ElectrolysisBL}, Facebook account {@electrolysisbeautylounge}, Pinterest account {electrolysisbeautylounge}, YouTube account {Electrolysis Beauty Lounge} and any other print or digital media accounts used to represent, market and/or brand Electrolysis Beauty Lounge, LLC.

I hereby release you, your representative, employees, managers, members, officers, parent companies, subsidiaries, and directors, from all claims and demands arising out of or in connection with any use of said "Materials", including, without limitation, all claims for invasion of privacy, infringement of my right of publicity, defamation and any other personal and/or property rights.

I acknowledge and agree that no sums whatsoever will be due to me as a result of the use and/or exploitation of the "Materials" or any rights therein.

Initials: ______

Client Acknowledgement of Information

I understand health history information is important to my Electrologist in order to provide me with safe and effective electrology treatments. I acknowledge all information given by me is accurate to the best of my knowledge, and I agree to update my health history assessment whenever there are changes.

I understand that a series of treatments is necessary to achieve permanent hair removal and my progress will be impacted by my personal hair growth rate, the science of electrology, and my individual physiological factors.

I understand my electrologist has the right to refuse treatment if it is not beneficial to my health or skincare due to known or unknown health conditions I may have.

Client Name: ______ Signature: ______ Date: MM / DD / YYYY

If under 18, parent/guardian must sign.

Parent's Name: ______ Parent's Signature: ______ Date: MM / DD / YYYY