IAME CLIENT HEALTH HISTORY

All questions contained in this questionnaire are strictly confidential.

Name: *(Last, First, M.I.)*		☐ M ☐ F	**DOB:** / /
Email Address:	**We will be confirming appts by email - please provide:**		
Street Address:			
City:		**State:**	**Zip:**
Mobile Phone:		**Home Phone:**	
How did you hear about IAME?			

IF YOU HAVE A HEART PROBLEM YOU MAY NOT RECEIVE A TREATMENT.

CONFIDENTIAL HEALTH INFORMATION

Are you **currently** under the care of a physician for your skin?	☐ No	☐ Yes	
Have you **ever** seen a physician for your skin?	☐ No	☐ Yes	
Are you **currently** taking Accutane®?	☐ No	☐ Yes	
Have you **ever** taken Accutane®?	☐ No	☐ Yes	Date of last dose:
Do you **currently** use Retin-A®?	☐ No	☐ Yes	
Do you **currently** use Hydroquinone?	☐ No	☐ Yes	
Have you **ever** used a topical fluorouracil preparation on your skin? (Carac®, Efudex®, Fluoroplex®)	☐ No	☐ Yes	Date: Body Location:
Have you any known Allergies to **anything**?	☐ No	☐ Yes: see box below	

If yes, please list **all** allergies: *(include medications, aspirin, food, fabrics, latex, etc.)*

ABILITY TO HEAL

Does your skin appear fragile or burn easily?
☐ No ☐ Yes

Do you have any problems healing from a cut or burn?
☐ No ☐ Yes

Do you **ever** use depilatories or waxes on your face?
☐ No ☐ Yes
If yes date last used:

Have you **ever** had a cold sore?
☐ No ☐ Yes
If yes date of last one?

Please list all oral medications you currently take: *(Include hormones, birth control pills, antibiotics, tranquilizers, anti-depressants, diuretics, etc.)*

Do you have any health problems?
Please explain:

Skin Condition

☐ Rosacea ☐ Acne ☐ Dehydrated
☐ Lax/Loose ☐ Millia ☐ Pigment
☐ Sun damage ☐ Broken capillaries
Other:

Skin Type

☐ Normal ☐ Dry ☐ Oily ☐ Combo
☐ Sensitive

How noticeable are your pores?
☐Very ☐T-Zone ☐Not Very

My last skin treatment was:

Date received:

Current skin products & brand used:

Client Treatment Consent and Release

I acknowledge that beauty treatments, the practice of skin care, and the practice of massage, including, but not limited to, microablation, microdermabrasion, waxing, electrolysis, facial toning, permanent cosmetics, body treatments, ionization, laser treatments, tattoo removal, vein treatments, brown spot removal, BOTOX, Collagen, Dermal Fillers, Sclerotherapy, Mesotherapy, Dermaplaning, and various other beauty procedures is not an exact science and no specific guaranties can or have been made concerning the outcome. I understand that some clients experience more change and improvement than others. In virtually all cases, multiple treatments are required in order to realize a difference**. I also understand and agree to assume the following risks and hazards which may occur in connection with any particular treatment including but not limited to: unsatisfactory results, soreness, poor healing, discomfort, redness, blistering, nerve damage, scarring, infection, change in skin pigmentation, allergic reaction, muscle damage, and increased hair growth. I understand that even though precautions may be taken in my treatment, not all risks can be known in advance.** Given the above, I understand that response to treatment varies on an individual basis and that specific results are not guaranteed. Therefore, in consideration for any treatment received, I agree to unconditionally defend, hold harmless and release from any and all liability the company and the individual that provided my treatment, the insured, and any additional insureds, as well as any officers, directors, or employees of the above companies for any condition or result, known or unknown, that may arise as a consequence of any treatment that I receive. **I have fully disclosed on my client intake form any medications, previous complications, or current conditions that may effect my treatment. I understand and agree that any legal action of any kind related to any treatment I receive will be limited to binding arbitration using a single arbitrator agreed to by both parties**.

X_____ _____ Date:_____
Client Signature Printed Name

Model Release In consideration for treatment received, I herby grant permission to the individual or company that provided my treatment to use any photographic treatment records for the purposes of clinical and statistical studies, advertising, or promotion without any additional compensation to me.

X_____ _____ Date:_____
Client Signature Printed Name