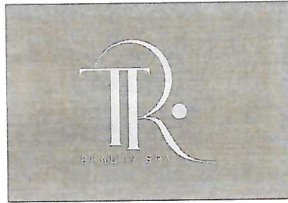


DIEM  
NGUYEN



# FACIAL TREATMENT

## CLIENT CONSULTATION FORM

Please fill out this form on your first appointment. Your answer will better help us to meet your needs and ensure that you have a happy and satisfying experience.

### CLIENT INFORMATION

Name: DIEM NGUYEN Date: \_\_\_\_\_  
Date of birth: \_\_\_\_\_ Age: 45  Female  Male  NB  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: 416 388 0363 Email: nguyentaca@gmail.com  
Your Occupation: \_\_\_\_\_  
Emergency contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

Would you like to be added to our email list for news and exclusive offers? Yes  No

### MEDICAL HISTORY

Do you have or have you had any of the following conditions? If yes, please select them:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Acne            | <input type="checkbox"/> Herpes              | <input checked="" type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> Arthritis       | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Lupus                         |
| <input type="checkbox"/> Asthma          | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Metal bone pins/plates        |
| <input type="checkbox"/> Blood disorder  | <input type="checkbox"/> HIV/AIDS            | <input type="checkbox"/> Phlebitis, blood clots        |
| <input type="checkbox"/> Cancer          | <input type="checkbox"/> Hyper pigmentation  | <input type="checkbox"/> Seizure disorder              |
| <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Hypo pigmentation   | <input type="checkbox"/> Skin disease/lesions          |
| <input type="checkbox"/> Eczema          | <input type="checkbox"/> Hysterectomy        | <input type="checkbox"/> Seborrhea                     |
| <input type="checkbox"/> Epilepsy        | <input type="checkbox"/> Immune disorders    | <input type="checkbox"/> Thyroid condition             |
| <input type="checkbox"/> Fever blisters  | <input type="checkbox"/> Insomnia            | <input type="checkbox"/> Varicose veins                |
| <input type="checkbox"/> Heart condition | <input type="checkbox"/> Keloid scarring     | <input type="checkbox"/> Warts                         |

Any other condition: \_\_\_\_\_

DIEM



# FACIAL TREATMENT

## CLIENT CONSENT FORM

I hereby consent to and authorize TR to perform the following procedure: \_\_\_\_\_.

I have voluntarily chosen to undergo this treatment/procedure after the nature and purpose of this treatment has been explained to me, along with the risks and hazards involved, by: \_\_\_\_\_.

Although it is impossible to list every potential risk and complication, I have been informed of possible benefits, risks, and complications. I also recognize there are no guaranteed results and that independent results are dependent upon age, skin condition, and lifestyle and that there is the possibility I may require further treatments of the treated areas to obtain the expected results at an additional cost.

I have read and understand the post-treatment home care instructions. I understand how important it is to follow all instructions given to me for post-treatment care. In the event that I may have additional questions or concerns regarding my treatment or suggested home product/post-treatment care, I will consult the esthetician immediately.

I have also, to the best of my knowledge, given an accurate account of my medical history, including all known allergies or prescription drugs or products I am currently ingesting or using topically.

***I have read and fully understand this agreement and all information detailed above. I understand the procedure and accept the risks. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. I do not hold the esthetician, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this skin care procedure, which may be affected by the treatment performed today.***

DIEM NGUYEN  
Client Name (printed)

Client Name (signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Esthetician (signature)

\_\_\_\_\_  
Date