

PATIENT/CLIENT INFORMATION	MEDICAL INFORMATION
DATE _____	DATE OF BIRTH _____ AGE _____ FAMILY PHYSICIAN _____
NAME _____	DO YOU SMOKE? _____ HOW OFTEN? _____ LIVING WITH A SMOKER? _____
EMAIL _____	HAVE YOU BEEN TREATED FOR: (PLEASE CHECK)
OCCUPATION _____	<input type="radio"/> ACNE <input type="radio"/> DEPRESSION <input type="radio"/> SKIN DISEASE <input type="radio"/> HIGH BLOOD PRESSURE
	<input type="radio"/> COLDSORES <input type="radio"/> DIABETES <input type="radio"/> CANCER
	LIST OF ALL ALLERGIES/ALLERGIC _____
	LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING _____
	ARE YOU PREGNANT? _____ TRYING TO GET PREGNANT? _____ HORMONE THERAPY? _____
	ARE YOU PRONE TO COLD SORES? _____

PERSONAL INFORMATION

CIRCLE YOUR CURRENT LEVEL OF STRESS: 1 2 3 4 5 6 7 8 9 10

CIRCLE YOUR NORMAL LEVEL OF STRESS: 1 2 3 4 5 6 7 8 9 10

HOW MANY OUNCES OF WATER DO YOU DRINK DAILY? _____ DO YOU TAKE SUPPLEMENTS/VITAMINS? _____

DO YOU EXERCISE? _____ IF SO, HOW OFTEN: _____ YOUR LAST SUNBURN? _____ DO YOU USE TANNING BEDS? _____

WHEN YOU GO OUT INTO THE SUN, DO YOU (CIRCLE CHECK ONE):

ALWAYS BURN (I) USUALLY BURN (II) SOMETIMES BURN(III) RARELY BURN (IV) VERY RARELY BURN (V) NEVER BURN (VI)

HAVE YOU EVER BEEN UNDER THE TREATMENT PLAN OF A:

DERMATOLOGIST PLASTIC SURGEON ESTHETICIAN

IF YES, WHAT PROCEDURE? _____

ARE YOU CONCERNED ABOUT SKIN CONDITIONS ON YOUR BODY? (CHECK ALL THAT APPLY)

SUN SPOTS SKIN LAXITY DRY / ROUGH

WHAT SKIN LINE ARE YOU CURRENTLY USING? _____

DO YOU USE A DAILY ENVIRONMENTAL PROTECTION PRODUCT (SUNBLOCK)? _____ IF NOT, WHY? _____

CIRCLE HOW YOU FEEL ABOUT THE OVERALL QUALITY OF YOUR SKIN:

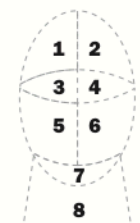
(BAD) 1 2 3 4 5 6 7 8 9 10 (FANTASTIC)

YOUR SKIN TYPE IS? (PLEASE CHECK ONLY ONE):

NORMAL DRY/DEHYDRATED OILY ACNE/ACNE PRONE ROSACEA

IN ORDER OF IMPORTANCE, PLEASE RANK 1 (MOST IMPORTANT) TO 5 (LEAST IMPORTANT) IMPROVEMENT IN THE NEXT 30 DAYS:

____ REDUCTION OF FINE LINES	____ ACNE SCARS DIMINISHED
____ REDUCTION OF BROWN SPOTS/SUN DAMAGE	____ REDUCTION OF REDNESS
____ REDUCTION OF OIL/ACNE	



1 RIGHT FOREHEAD 5 LEFT CHEEK

2 LEFT FOREHEAD 6 RIGHT CHEEK

3 LEFT EYE AREA 7 CHIN

4 RIGHT EYE AREA 8 NECK

TREATMENT PLAN (TO BE COMPLETED BY PHYSICIAN/ESTHETICIAN)

PROFESSIONAL TREATMENT RECOMMENDATION

ORMEDIC LIFT LIGHTENING LIFT ACNE LIFT IMAGE PERFECTION LIFT

SIGNATURE LIFT WRINKLE LIFT ACNE ADVANCED LIFT

THANK YOU FOR COMPLETING THIS CONFIDENTIAL QUESTIONNAIRE.
THIS INFORMATION WILL ALLOW YOUR PROFESSIONAL SKIN CARE SPECIALIST TO PROVIDE THE OPTIMUM IMAGE PRODUCTS AND SERVICES.

SIGNATURE: _____ DATE: _____

PATIENT/CLIENT INFORMATION

DATE _____
 NAME _____
 EMAIL _____

TREATMENT (Please initial by each statement)

_____ The treatment was explained to me in detail.
 _____ The benefits of what I can realistically expect to see from my Clinical Peel have been fully explained to me.

TREATMENT (Please select one)

_____ ORMEDIC LIFT
 _____ SIGNATURE LIFT
 _____ LIGHTENING LIFT
 _____ WRINKLE LIFT
 _____ ACNE LIFT
 _____ ACNE ADVANCED LIFT
 _____ IMAGE PERFECTION LIFT
 _____ TCA ORANGE LIFT

SKIN CONDITION (Please select all that apply)

_____ SUPERFICIAL WRINKLES, FINE LINES
 _____ DEEP WRINKLES, FINE LINES
 _____ ACNE OR ACNE PRONE
 _____ DEEP HYPERPIGMENTATION (SUN OR BROWN SPOTS)
 _____ SEVERE PHOTOAGING
 _____ ROSACEA
 _____ DEHYDRATION
 _____ ACNE SCARS
 _____ UNBALANCED

PRECAUTIONS (Please Read Carefully)

The Treatment you will receive is a clinical treatment designed to exfoliate or remove the outer layers of the skin.
Your participation in your skin care treatments will determine the outcome. It is important that you strictly adhere to your home care products that your esthetician has recommended.
No guarantee is expressed or implied as to the precise results, peeling times or discomfort.
During the treatment, you may experience some temporary stinging or warm flushing. This will fade within a few minutes. During the next few hours, you may experience some tightening of the skin, which may last for several days.
For most patients, flaking begins within 48 hours. It is impossible to pre-determine how much peeling will occur. The shedding process usually subsides within 5-7 days.
Depending on the clinical peel performed and your skin quality, the following reactions may occur in some patients:
 1) Prolonged redness, irritation & flakiness 2) Dryness and sensitivity 3) Severe allergic reactions in rare instances

PLEASE INITIAL (Please Read Carefully)

_____ I AM NOT PREGNANT.**	_____ I DO NOT HAVE ACTIVE COLD SORES.
_____ I AM NOT ALLERGIC TO ASPIRIN.	_____ I HAVE NOT RECEIVED RADIATION TREATMENTS.
_____ I HAVE NOT USED GLYCOLIC FOR 24 HRS.	_____ I AGREE IT IS MANDATORY TO USE IMAGE POST PEEL KIT.
_____ I HAVE NOT USED RETINOL PRODUCTS FOR 72 HRS.	_____ I AGREE TO AVOID DIRECT SUN EXPOSURE FOR 2 WEEKS.
_____ I HAVE NOT TAKEN ACCUTANE IN THE PAST YEAR.	_____ I AGREE TO NOTIFY DR/AESTHETICIAN OF ANY CONCERNS.
_____ I AGREE NOT TO PICK, PEEL, OR SCRATCH THE SKIN DURING HEALING PHASE.	_____ I AGREE TO APPLY IMAGE DAILY DEFENSE DAILY.
_____ I AGREE THERE MAYBE CRUSTING & SHEDDING OF SKIN.	_____ I AGREE NOT TO WAX FOR 7 DAYS PRE/POST TREATMENT.
_____ A PRIOR PATCH TEST HAS BEEN GIVEN TO ME TO RULE OUT ANY ALLERGIC TENDENCIES.	_____ I AGREE TO FOLLOW UP WITH SCHEDULED APPOINTMENT.
_____ I AGREE THAT I CURRENTLY DO NOT USE HYDROCORTISONE.	_____ I AGREE NOT TO USE RETIN-A PRODUCTS 5 DAYS PRE/POST TREATMENTS
	_____ I AM UNDER THE SUPERVISION OF A PHYSICIAN AND HAVE DISCUSSED THE TREATMENT PLAN WITH MY PHYSICIAN.

CONSENT (Please sign)

I hereby give my consent and authorization voluntarily and release _____ (Name of business) from any claims, implied or stated that I have or may have in the future with this treatment, regardless of result. I am stating that the treatment and precautions above have been explained to me in detail and that I fully understand.

CLIENT SIGNATURE: _____ DATE: _____

WITNESS: _____ DATE: _____