Neroli
Institute

☐ 6051 Arlington Blvd, Suite B,
Falls Church, VA 22044
703.241.2173

☐ 1880 Howard Ave, Suite 203
Vienna, VA 22182
703-356-6143

HEALTH HISTORY INFORMATION

NAME **Today's Date:**

LAST: **FIRST:** **M.I:**

HOME ADDRESS:

DATEOF BIRTH: **AGE:** **Sex:** **Female** ☐ **Male** ☐

HOME PHONE: **CELL PHONE:**

EMAIL:

I consent to this email address to be added to the Med Spa and will be used to send email and newsletter, where I will get information on specials and promotions. Yes ☐ **No** ☐

LEAVE MESSAGES AT: Home ☐ **Cell** ☐ **Email** ☐

OCCUPATION:

PRIMARY CARE PHYSICIAN|PHONE NUMBER:
IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED? [name and phone]

UNLESS OTHERWISE INDICATED, WE HAVEPERMISSION TOCOMMUNICATE CHANGES IN YOUR HEALTH STATUS, INCLUDING SURGERY, TO OTHER PHYSICIANS PARTICIPATINGIN YOURCARE.
Yes, May Notify ☐ **No, Please Do Not Notify** ☐

DOYOU HAVE ANY MAJORMEDICAL PROBLEMS, SERIOUS ILLNESS? Yes ☐ **No** ☐
IF SO, PLEASE LIST:
PLEASE LIST ALL PRIOR SURGICAL PROCEDURES ANDDATESPERFORMED:

PLEASE LIST ALL INJECTABLE PROCEDURES {Botox, Jevederm, Restylane, Collagen, etc.} AND DATES PERFORMED.

MEDICAL HISTORY

DO YOU HAVE APACEMAKER OR DEFIBRILLATOR?..... ☐

DO YOU SUFFER FROM "PHOTOSENSITIVITY" {EXTREME SENSITIVITY TOSUNLIGHT} ..... ☐

DO YOU HAVE A HISTORY OF EASY/EXCESSIVE HYPERPIGMENTATION?..... ☐

DO YOU FORM KELOID SCARS?..... ☐

DO YOU HAVE ANY METAL IMPLANTS?..... ☐

DO YOU WEAR CONTACT LENSESES?..... ☐

HAVE YOU TAKEN ACCUTANE, RETIN A, OR RENOVA IN THE PAST 12MONTHS?..... ☐

ARE YOU CURRENTLY TAKINGCOUMADIN [Warfarin]OR OTHER BLOOD THINNERS?..... ☐

DO YOU REQUIRE ANTIBIOTICS BEFORE PROCEDURES SUCH AS DENTAL CLEANINGS?..... ☐

DO YOU SMOKE? Yes ☐ No ☐ IF YES, HOW MANY PACKSPER DAY?

DO YOU DRINK ALCOHOL? Yes ☐ No ☐ IF YES, QUANTITY PER WEEK?

HAVE YOU EVER HAD AN ADVERSE REACTIONTO LASER OR COSMETIC TREATMENTS?
Yes ☐ No ☐ IF SO, PLEASE LIST:

ARE YOU ALLERGIC TO ANY MEDICATIONS?..... ☐
IF SO, PLEASE LIST:

DO YOU HAVE ANY OTHER ALLERGIES?..... ☐
IF SO, PLEASE LIST:

DO YOU TAKE ANY OF THE FOLLOWING **[Please check]:**

- ☐ **all that apply and/or list additional medications**
- ☐ **ANTI-COAGULANTS**
- ☐ **ANTI-DEPRESSANTS**
- ☐ **APPETITE DEPRESSANTS**
- ☐ **ASPIRIN OR IBUPROFEN**
- ☐ **BLOOD PRESSURE MEDICATION**
- ☐ **CORTISONE OR STEROIDS**
- ☐ **ANTIBIOTICS**
- ☐ **HORMONES/CONTRACEPTIVES**
- ☐ **NSULIN**
- ☐ **NSAIDS**
- ☐ **SEDATIVES**
- ☐ **THYROID MEDICATION**
- ☐ **OTHER**

ARE YOU TAKING HERBAL PREPARATIONS OR VITAMINS [St. JohnsWort, Vitamin E, etc.]? **Yes** ☐ **No** ☐
ARE YOU OR MIGHT YOU BE PREGNANT?..... **Yes** ☐ **No** ☐
ARE YOU TRYING TO BECOME PREGNANT?..... **Yes** ☐ **No** ☐
ARE YOU NURSING?..... **Yes** ☐ **No** ☐

HAVE YOU EVER HAD ANY PROBLEMS WITH ANY OF THE FOLLOWING ANESTHETICS? IF SO, PLEASE SPECIFY:

- ☐ **BLOCK [e.g., dental]: Ineffective |Heart palpitations |Systemic reaction| Other:**
- ☐ **LOCAL: Ineffective |Heart palpitations |Systemic reaction| Other:**
- ☐ **TOPICAL: Ineffective |Heart palpitations |Systemic reaction| Other:**

HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING [Please check all that apply]:

- ☐ **Active Infection**
- ☐ **Arthritis**
- ☐ **Asthma**
- ☐ **Bleeding Disorders**
- ☐ **Blistering Sunburns**
- ☐ **Circulation Problems/Blood Clots**
- ☐ **Cold Sores/Shingles**
- ☐ **Collagen Disorders**
- ☐ **Diabetes (Type__)**
- ☐ **Easy Bruising**
- ☐ **Endocrine/Hormonal Issues**
- ☐ **Eye Problems**
- ☐ **Fatigue**
- ☐ **Fibromyalgia**
- ☐ **Headaches/Migraines**
- ☐ **Heart Condition**
- ☐ **Hepatitis**
- ☐ **High/Low Blood Pressure**
- ☐ **Other**
- ☐ **Hormonal Imbalance**
- ☐ **Insomnia/Sleeping Problems**
- ☐ **Joint Injury**
- ☐ **Multiple Sclerosis**
- ☐ **Muscle Pain/Spasms**
- ☐ **Neurological Disorders**
- ☐ **Permanent Makeup/Tattoo**
- ☐ **Pigmentation Disorders**
- ☐ **Psoriasis**
- ☐ **Melanoma**
- ☐ **Scleroderma**
- ☐ **Skin Cancer**
- ☐ **Skin Injury**
- ☐ **Stroke**
- ☐ **Unusual Moles**
- ☐ **Varicose Veins**
- ☐ **Vision Deficits**
- ☐ **HIV/AIDS**

SKIN CARE HISTORY AND CONCERNS

PLEASE LIST ANY PRODUCTSTHATIRRITATEYOUR SKIN:

HAVE YOU HAD UNPROTECTED SUN EXPOSURE OR BEEN IN A TANNINGBOOTH IN THE LAST 2 WEEKS? Yes ☐ No ☐

DOYOU USE SELF TANNERS? Yes ☐ No ☐ IF YES, WHEN WAS THE LAST APPLICATION?
ARE YOU PLANNING A VACATIONIN THE SUN IN THE NEXT 3-6MONTHS? Yes ☐ No ☐

HAVE YOU USED ANY OF THE FOLLOWING HAIR REMOVAL METHODS IN THE PAST6WEEKS?
SHAVING ☐ WAXING ☐ ELECTROLYSIS ☐ PLUCKING/TWEEZING ☐ STRINGING ☐
EPILATORIES ☐
PLEASE INDICATEYOUR CURRENT SKIN CARE PRODUCTS/REGIMEN:

THERAPIST/PROVIDERREVIEWED: SIGNATURE _____ DATE_____
THERAPIST PRINTED NAME:

EXCLUSIONARY CRITERIA FORM

Yes ☐ No ☐	**I have had unprotected sun exposure, used a tanning Bedor applied a tanning cream inthe area(s) to be treated within the six weeks prior to my first treatment on a regular basis (tanned skin will not be treated with laser). Protected sun exposure means wearingprotective clothing or the daily use of an SPF-30 or greater sunscreen.**
Yes ☐ No ☐	**I have used a mechanical form of epilation with the six weeks prior to my first treatment (this applies to laser hair removal treatments only.) Mechanical epilation includes Plucking, waxing, tweezing, electrolysis, threading, or sugaring.**
Yes ☐ No ☐	**I have a history of seizures. Flashing lights may trigger a seizure.**
Yes ☐ No ☐	**Medications I am taking Accutane, anticoagulants or St.John's Wort. I am taking a medication or herbal remedy that may make my skin sensitive to light (photosensitizing).**
Yes ☐ No ☐	**I have a history of keloid and hypertrophic scar formation. Although scarring is rare, picking or pulling off scabs or crusting can result in scarring. For this reason, it is recommended to exclude from treatment clients with known tendency to form keloid or hypertrophic scars. Clients with this history are evaluated on a case-by-case basis to determine if treatment can be performed.**
Yes ☐ No ☐	**I have an active infection or am immune suppressed. (Active infections and immuno- suppression compromise the healing ability of the body).**
Yes ☐ No ☐	**I have an open lesion in the area to be treated.**
Yes ☐ No ☐	**I have a history of Herpes I or II within the area to be treated.**
Yes ☐ No ☐	**I am using or have used within the two weeks prior to treatment Tretinoin (Retin-A, Renova) or a retinol product in the area to be treated.**

PLEASENOTE A “YES” TO ANY OF THE ABOVE MAYEXCLUDE CLIENT FROMTHE LIGHT THERAPY (LASER/IPL) TREATMENTS.

PRINT CLIENT NAME:

SIGNATURE: DATE:

WITNESS: DATE:

MY SPECIFICCONCERNS AND INTERESTS

Please check all that apply and indicate any prior treatments in space provided)

CONCERNS	LIST ANY PRIOR TREATMENT AND APPROXIMATE DATE(S): [Accutane/Botox/Peels/IPL/Lasers/Surgery/etc.]
◯ Skin discoloration	
◯ Brown Spots	
◯ Acne	I have used Accutane: Yes ◯ No ◯ Last Dose:
◯ Rosacea	
◯ Fine Wrinkles	
◯ Lip Lines	
◯ Thin Lips	
◯ Nasolabial Creases	
◯ Marionette Lines	
◯ Loose Skin	
◯ Aging Hands	
◯ Excessive Sweating	
◯ Facial/Body Hair	
◯ Scars	
◯ Facial Veins	
◯ Leg Veins	
◯ Not Certain	
◯ Toenail Fungus	
◯ CoolSculpting Body Contouring	
◯ Other	

CLIENT SIGNATURE: **DATE:**

PRINTEDNAME:

PROVIDER NAME ANDSIGNATURE: **DATE:**

Deep Cleansing Facial Waiver & Consent Form

1. Treatment Description:

- Double cleansing
- Exfoliation (enzymatic or mechanical)
- Steam
- Extractions
- High-frequency (if applicable)
- Mask treatment
- Moisturizer and SPF application

I acknowledge that this treatment is designed to clean pores, remove impurities, and improve skin texture, but results may vary.

2. Health & Skin History

I confirm that I have informed my esthetician of all medical and skin conditions, including but not limited to active acne, rosacea, eczema, allergies, recent chemical peels, laser treatments, medications, or Accutane.
List any conditions, allergies, or medications:

_____

3. Risks & Side Effects

I understand that potential side effects include redness, irritation, temporary sensitivity, breakouts, and mild discomfort during extractions.

4. Extraction Consent

I understand extractions may cause temporary redness or tenderness.

☐ YES, I consent to extractions

☐ NO, I do NOT consent to extractions

5. Contraindications

I confirm that I do not have active infections and have informed my esthetician about any recent botox, filler, or dermatological treatments.

6. Informed Consent

I voluntarily agree to receive this treatment. I understand results are not guaranteed, and I will follow after-care instructions.

8. Acknowledgment

I confirm that I have read and agree to the terms of this waiver.

Client Signature: _____ Esthetician Signature: _____

Date: _____ Date: _____

Dermaplaning Waiver

What is Dermaplaning?

Dermaplaning is a form of manual exfoliation similar in theory to microdermabrasion but without the use of suction or abrasive crystals. An esthetician grade, sterile blade is stroked along the skin at an angle to gently "shave off" dead skin cells from the epidermis. Dermaplaning also temporarily removes the fine vellus hair of the face, leaving a very smooth surface.

As with any type of exfoliation, the removal of dead skin cells allows home care products to be more effective, reduces the appearance of fine lines, evens skin tone and assists in reducing milia, closed and open comedones, and minor breakouts associated with congested pores.

Dermaplaning can be an effective exfoliation method for clients that have couperose (tiny blood vessels near the surface of the skin), sensitive skin or allergies that prevent the use of microdermabrasion or chemical peels.

Due to the contours of the face, certain areas of the face (such as the eyelids and nose) are not treatable using this method.

_____ Client Initials

What should you expect during your treatment?

As your esthetician, I will perform a thorough skin analysis prior to your first dermaplaning.

If dermaplaning is not appropriate, you will be informed during this session and an alternative treatment may be recommended instead.

If dermaplaning is not contraindicated, maximum results are obtained by participating in a series of treatments plus following a home care regimen.

I will review your current daily regimen and skin care products, advise you on which products you should continue to use, and recommend any additional products or changes to your regimen to enhance your desired outcome.

_____ Client Initials

As your esthetician, I take every precaution to ensure that your skin is well hydrated and calm following each session. However, you may experience excessive dryness or even some peeling between sessions, which may or may not be normal. Always contact me if you have any concerns.

More sensitive skin may experience some redness after the first couple of sessions. This normally goes away after 2 to 3 hours. Dermaplaning may cause minor superficial abrasions which may not appear until a day or two following your treatment. If this should occur, please contact me so that I can do a post-treatment follow up with you.

After your treatment, SPF 30+ MUST be worn at all times. Tanning beds should never be used. You are making an investment in your skin: therefore, it is to your benefit to continue to protect it long after your series of treatments is completed.

_____ Client Initials

Is satisfaction guaranteed?

The majority of my clients receive noticeable, satisfactory to above average results with a series of treatments and a commitment to a daily skin care regimen. However, this outcome cannot be guaranteed as maximum results are highly dependent on age, cumulative sun exposure, health, lifestyle, genetic traits, general skin condition, and willingness to follow recommended protocols.

Be aware that many changes may occur deeper within the skin over time. To continue the maintenance of your skin after you complete your treatment(s), I may inform you of long-term age management programs.

_____ Client Initials

Contraindications

Although it is impossible to list every potential risk and complication, the following conditions are recognized as contraindications for dermaplaning treatment and must be disclosed prior to treatment.

• Active acne

• Active infection of any type, such as herpes simplex or flat warts.

• Any raised lesions

• Any recent chemical peel procedure

• Chemotherapy or radiation

• Eczema or dermatitis

• Family history of hypertrophic scarring or keloid formation

• Hemophilia

• Hormonal therapy that produces thick pigmentation

• Moles

• Oral blood thinner medications

• Pregnancy

• Recent use of topical agents such as glycolic acids, alpha-hydroxy acids Retin-A • Rosacea

• Scleroderma

• Skin Cancer

• Sunburn

• Tattoos

• Telangiectasia/erythema may be worsened or brought out by exfoliation

• Thick, dark facial hair

• Uncontrolled diabetes

• Use of Accutane within 12 months

• Vascular lesions

_____ Client Initials

_____ _____

Client Name (printed) Date

_____ _____

Name (signature) Date

_____ _____

Esthetician Date

Post-Treatment/Home Care (Client Copy)

Aerobic exercise or vigorous physical activity should be avoided until all redness has subsided. Direct sunlight exposure is to be completely avoided immediately following the treatment (including any strong UV light exposure or tanning beds). Although SPF 30+ should already be a part of your daily skin care, after dermaplaning, SPF 30+ must be applied daily to the treated area for a minimum of two weeks. Twice daily cleanse the treated area with a post- treatment cleanser, followed by a serum or treatment cream and follow with SPF 30+ sunscreen.

Recommended Products:

_____

_____

_____

If you have additional questions or concerns regarding your treatment or suggested home regimen, please consult your esthetician immediately.

INFORMED CONSENT FORM – HYDRADERMABRASION AND MICRODERMABRASION

Client Name: **Date:**

Treatment Sites:

I duly authorize Neroli Med Spa's technicians to perform _____ treatment.
I understand that clinical results may vary depending on individual factors, including but not limited to medical history, skin type, patient compliance with pre and post treatment instructions, and individual response to treatment.

Initials _____

I understand that there is a possibility of short-term effects such as reddening, mild burning, temporary bruising, and temporary discoloration of the skin, as well as the possibility of rare side effects such as scarring and permanent discoloration. These effects have been fully explained to me.

Initials _____

I understand that treatment with the _____ involves a series of treatments and the fee structure has been fully explained to me.

Initials _____

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and I understand that no guarantee can be given as to the final result obtained. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so.

Initials _____

I confirm that I have informed the staff regarding any current or past medical condition, disease or medication taken.

Initials _____

I consent to the taking of photographs and authorize their anonymous use for the purpose of medical audit, education and promotion.

Initials _____

I hereby commit myself not to leave any comments or information in any social media or elsewhere, or communicate with any entity, any such comments or information that may damage the reputation of Neroli in any form or extent whatsoever, and will only share any such comments and feedback with Neroli.

Initials _____

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form.

Initials _____

Refund, Return and Cancellation Policy

As a courtesy to other spa guests and our therapists, please give at least a 48-hour notice of cancellation to avoid a $25 charge or as a penalty one of your sessions taken away. A credit-card number, advanced payment, or gift-certification number may be required at the time of booking. For spa packages and two or more guests coming together we require a 48-hour cancellation notice. Groups and bridal parties will require a 50% deposit at the time of booking. A refund is not available after you have used a portion of the services you booked. After one session the fee for a package of two is non-refundable. Please ask new update of our staff about our refund and return and cancellation policy. Educational programs: After two sessions the fee for programs is non-refundable. We do not provide refunds for cancelled or missed appointments.

Client Signature: _____

Date: _____