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

Intense Pulsed Light (IPL)

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**	☐ **ANTIBIOTICS**
☐ **ANTI-COAGULANTS**	☐ **HORMONES/CONTRACEPTIVES**
☐ **ANTI-DEPRESSANTS**	☐ **NSULIN**
☐ **APPETITE DEPRESSANTS**	☐ **NSAIDS**
☐ **ASPIRIN OR IBUPROFEN**	☐ **SEDATIVES**
☐ **BLOOD PRESSURE MEDICATION**	☐ **THYROID MEDICATION**
☐ **CORTISONE OR STEROIDS**	☐ **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 in the 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 wearing protective 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:**

PROVIDER NAME AND SIGNATURE: DATE:

THE FITZPATRICK SKIN-TYPE CHART

You can use this skin-type chart for self-assessment, by adding up the score for each of the questions you've answered. At the end there is a scale providing a range for each of the six skin-type categories. Following the scale is an explanation of each of the skin types. You can quickly and easily determine which skin type you are.

GENETIC DISPOSITION

Score	**0**	**1**	**2**	**3**	**4**
What is the color of your eyes?	Light blue, Grey, Green ☐	Blue, Grey, Green ☐	Blue ☐	Dark Brown ☐	Brownish Black ☐
What is the natural color of your hair?	Sandy Red ☐	Blond ☐	Chestnut/ Dark Brow ☐	Dark Brown ☐	Black ☐
What is the color of your skin (non-exposed areas?)	Reddish ☐	Very Pale ☐	Pale with Beige tint ☐	Light Brown ☐	Dark Brown ☐
Do you have freckles on unexposed areas?	Many ☐	Several ☐	Few ☐	Incidental ☐	None ☐

TOTAL SCORE FOR GENETIC DISPOSITION: _______________

REACTION TO EXPOSURE

Score	0	1	2	3	4
What happens when you stay in the sun too long?	Painful redness, blistering, pooling ☐	Blistering followed by peeling ☐	Burns sometimes followed by peeling ☐	Rare Burns ☐	Never had Burns ☐
To what degree do you turn brown?	Hardly or not at all ☐	Light color tan ☐	Reasonable tan ☐	Tan very easy ☐	Turn dark brown quickly ☐
Do you turn brown within several hours after sun exposure?	Never ☐	Seldom ☐	Sometimes ☐	Often ☐	Always ☐
Do you have freckles on unexposed areas?	Very Sensitive ☐	Sensitive ☐	Normal ☐	Very resist ance ☐	Never had a proble m ☐

TOTAL SCORE FOR REACTION TO SUN EXPOSURE: ________________

TANNING HABITS

Score	0	1	2	3	4
When did you last expose your body to sun [or artificial sun lamp/tanning cream?	More than 3 months ago ☐	2-3 months a go ☐	1-2 months a go ☐	Less than a month ☐	Less than 2 weeks ☐
Did you expose the area to be treated to the sun?	Never ☐	Hardly ever ☐	Sometimes ☐	Often ☐	21 ☐

TOTAL SCORE FOR TANNING HABITS: __________

Add up the total scores for each of the three sections for your Skin Type Score. **

Neroli
Institute

SKING TYPE SCORE – FITZPATRIK SKING TYPE

0-7	I
8-16	II
17-25	III
25-30	IV
Over 30	V-VI

TYPE 1: Highly sensitive, always burns, never tans.
Example: Red hair with freckles.

TYPE 2: Very sun sensitive, burns easily, tans minimally.
Example: Fair skinned, fair haired Caucasians.

TYPE 3: Sun sensitive skin, sometimes burns, slowly tans to light brown.
Example: Darker Caucasians.

TYPE 4: Minimally sun sensitive, burns minimally, always tans to moderate brown.
Example: Mediterranean type Caucasians, some Hispanics.

TYPE 5: Sun insensitive skin, rarely burns, tans well.
Example: Some Hispanics, some Blacks.

TYPE 6: Sun insensitive, never burns, deeply pigmented.
Example: Darker Blacks.

Neroli Institute

Intense Pulsed Light (IPL) Consent Form

The Intense Pulsed Light (IPL) device used for the treatment of benign pigmented and vascular skin lesions and rejuvenation and acne. IPL treatments are a series of approximately 4 to 6 treatments performed at approximately 2 week intervals. Actual results vary from patient to patient. The IPL treatment is a cosmetic procedure and insurance is not accepted.

The procedure is contraindicated in the following situations: pregnancy, the use of medications that cause photosensitivity (sensitivity to sunlight/light), the use of anticoagulants (blood thinners), a history of bleeding disorders, sun exposure (tanning) 3weeks prior to treatment, or planned sun exposure within 1 week after any treatment. Diseases that increase sensitivity to sunlight/light(Lupus/SLE) or very dark skin types also should not undergo IPL treatments.

I understand that there are possible risks to these treatments, similar to any other medical procedure. These risks include rare side effects such as scarring and permanent skin discoloration as well as short- term effects such as redness, burning, bruising and temporary skin discoloration. These side effects have all been fully explained to me and I accept the risks of the IPL treatment series.

I understand that IPL treatments may affect hair growth. For this reason, we do not treat over men's bearded areas unless expressly discussed with the R.N.

To achieve optimal results from the IPL treatment series, we strongly encourage maintenance treatments. Usually this consists of 1 treatment every 2-4 weeks depending on skin conditions.

I consent to the taking of photographs during the course of my laser therapy for the purpose of monitoring the progress of treatment. These photographs will remain in the medical chart and will not be used for any other purposes.

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.

Patient Signature: ________________________________ Date: _______________

Patient Name: ___________________________________
(Please Print)

Witness: ______________________________________Date: ____________

POLICIES

24 HOURS CANCELLATION POLICY

Confirmation of your appointments is a courtesy call not an obligation. It is the client's full responsibility to keep track of his/her scheduled appointments. If a client fails to notify of appointment cancellation at least 48 hours in advance, the no-show will be counted as used treatment of the client's package deal or a $40.00 fee must be paid to accommodate the licensed technician time. For any credit card payments, a 10% surcharge and merchant fee will be deducted in case of any refunds 14(fourteen) days after original transaction.

PACKAGE REFUND POLICY

By signing this No Refund policy, I am agreeing that any service(s), service package(s) , gift certificate(s), and/or retail product(s) purchased will not be refunded or issued a credit. refunded or issued a credit. I also understand that if I decide to cancel or postpone any service(s), service package(s),gift certificate(s), and/or retail product(s), I will forfeit all money paid, including any deposits and/or payments I have already paid.All package payments should be completed in full before no more than half of the services have been used.

Full Name:

Signature:

Date: ___/__/_____

For Official Use Only

Purchase package :

Number of package :

Expiration :

Officer Signature :

I agree with all terms and conditions