KAMALA, THE CENTER FOR RADIANT HEALTH

FACIAL AND WAXING TREATMENT FORM

NAME_____DOB_____

ADDRESS_____

CITY_____STATE_____ZIP_____

PHONE (H)_____(W)_____(C)_____

E-MAIL_____OCCUPATION_____

REFERRED BY_____

REASON FOR VISIT_____

PLEASE STATE ANY PAST OR PRESENT INJURIES, MEDICAL TREATMENTS or FACIAL SURGERIES:_____

_____

PLEASE CIRCLE ANY OF THE FOLLOWING CONDITIONS YOU HAVE CURRENTLY; UNDERLINE ANY CONDITIONS YOU HAVE HAD IN THE PAST.

NECK/SPINE INJURY	HIGH BLOOD PRESSURE	LIVER AILMENT
BACK PAIN	LOW BLOOD PRESSURE	KIDNEY AILMENT
SCIATICA/LEG PAIN	SKIN DISORDERS	HEART AILMENT
INFECTIOUS DISEASE	TMJ SYNDROME	DIABETES
HEADACHE	ARTHRITIS	CANCER
INGREDIENT SENTIVITIES	ALLERGIES	COLD/FLU/FEVER
VARICOSE VEINS	PREGNANCY	BLOOD CLOTS

OTHER_____

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN OR DERMATOLOGIST?_____Yes _____NO

WHOM?_____

PLEASE LIST ANY MEDICATIONS TAKEN NOW OR AT REGULAR INTERVALS

_____

_____

Accutane within last 7 years _____Yes _____No
Glycolic, Other Chemical Peel or Retin-A within last 6 months: _____Yes _____No
Prednisone within last 6 months: _____Yes _____No

THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I AGREE TO UPDATE MY FACIALIST ON ANY CHANGES THAT OCCUR WITH MY HEALTH OR MEDICATIONS. I UNDERSTAND THAT NURSES AND FACIALISTS DO NOT DIAGNOSE DISEASE, PRESCRIBE MEDICATIONS OR MANIPULATE BONES. I FURTHER UNDERSTAND THAT THE THERAPY I RECEIVE TODAY IS NOT A SUBSTITUTE FOR MEDICAL ATTENTION OR EXAMINATION. ALL INFORMATION GIVEN HERE AND SHARED WITH THE THERAPIST DURING MY APPOINTMENT IS CONFIDENTIAL, AND WILL NOT BE RELEASED WITHOUT MY WRITTEN PERMISSION.

SIGNATURE_____DATE_____

We ask our clients to pay at the end of each visit, unless other financial arrangements have already been made. The time of your appointment is reserved for you. Please give us 24 hours notice if you are unable to keep your appointment. ***We reserve the right to charge in full for no shows and cancellations without 24 hour notice.***

RELEASE

INITIAL UNDERSTANDING FOR EACH STATEMENT:

_____I understand that the facial therapy or treatmente services which I receive are designed to be a health aid for the purpose of relaxation, stress reduction, and relief of muscular tension, and are in no way to take the place of a doctor's care when such care is indicated. If I experience any pain or discomfort during the session I will immediately inform the therapist so that the therapy may be adjusted to my level of comfort.

_____I also understand that information exchanged during the session is educational in nature, and is intended to help me become familiar and conscious of my own health status, is held in confidence and to be used/shared only with my written permission.

_____I understand that the facialist not qualified to diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session(s) given should be construed as such.

_____Because favials, some add on therapies and waxing treatments are contraindicated (should not be done) under certain medical conditions, I affirm that I will take the responsibility for keeping the therapist updated on all changes in my health status and medications, and that there is no liability on the part of the therapist should I not do so. In accordance with Texas law governing the transmission of infectious disease, I have stated all known medical conditions and answered all questions honestly.

_____I understand that prescriptions or products can cause unexpected skin sensitivity/reactions to ingredients, and will hold the therapist harmless for unforeseen skin reactions/sensitivity.

_____I understand that proper draping procedures will be used at all times.

_____ I also understand that any illicit or sexually suggestive remarks or advances made by me will result in the immediate end of the session, and **I will be liable for payment in full of the appointment.**

POLICIES

Please understand your time commitment begins at the moment you reserve a facial or waxing treatment. In order to make it fair for everyone, please consider your schedule carefully and don't commit to a time you feel may be questionable. There are times when a cancellation is, of course, necessary; but please give advanced notice whenever possible. I hereby authorize that a missed or canceled appointments (medical emergencies excluded) without twenty-four (24) hour notice **may be charged in full** for the missed session.

I have read and understand the above policy.

Signature_____Date_____

VISIT NOTES