LASER HAIR REMOVAL

Consultation Form

CLIENT INFORMATION

Name: ______________________ D.O.B: __________

Occupation: ______________ Age: ________ ☐ Female ☐ Male ☐ NB

Address: ______________________________

City: ______________ State: ________ Zip: ____________

Phone: ____________ Email: ______________________

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:

- ☐ Acne
- ☐ Active Infection
- ☐ Anaphylaxis
- ☐ Arthritis
- ☐ Autoimmune Disease
- ☐ Bell's Palsy
- ☐ Bleeding Disorders
- ☐ Breathing Problems/Disease
- ☐ Cold Sores (HSV1)
- ☐ Liver/Kidney Dysfunction
- ☐ Diabetes
- ☐ Eczema/Rashes
- ☐ Epilepsy/Seizures
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes (HSV2)
- ☐ Hirsutism
- ☐ HIV/AIDS
- ☐ Hypo/Hyper Pigmentation
- ☐ Hysterectomy
- ☐ Implantable Defibrillator
- ☐ Irregular Periods
- ☐ Keloid Scarring
- ☐ Low/High Blood Pressure
- ☐ Menopause
- ☐ Multiple Sclerosis/ALS
- ☐ Lesions, Open wounds
- ☐ Lupus
- ☐ Pacemaker
- ☐ Photosensitivity
- ☐ Polycystic Ovaries
- ☐ Poor Blood Circulations
- ☐ Pregnant
- ☐ Psoriasis
- ☐ Shingles
- ☐ Skin Cancer
- ☐ Thyroid Imbalance
- ☐ Vitiligo
- ☐ Warts

Any other conditions? ______________________________

Are you currently under a doctor's care? ☐ No ☐ Yes

If yes, please explain: ______________________

Have you ever been treated for cancer? ☐ No ☐ Yes

If yes, please explain: ______________________

Do you have any implants? ☐ No ☐ Yes

If yes, please explain: ______________________

Have you ever been treated with hormone medication? ☐ No ☐ Yes

If yes, please explain: ______________________

Have you had any severe reactions to histamines? ☐ No ☐ Yes

If yes, please explain: ______________________

Any previous surgeries? ☐ No ☐ Yes

If yes, please explain: ______________________

Do you have any allergies? ☐ No ☐ Yes

If yes, please list all: ______________________

List all medications you take, including vitamins, herbal supplements, aspirin, hormones and topical:

____

♀ When is your next menstrual cycle due to begin? ____________

(For your comfort, allow five days for your menstrual cycle. Avoid hair removal two days before your cycle is due and two days after it is completed.)

Are you pregnant, trying to become pregnant or nursing? ☐ No ☐ Yes

SKIN HISTORY

Have you used Accutane or Immunosuppressants in the last 6 months? ☐ No ☐ Yes

Any Retin-A, Retinol, AHA or acid-containing products in the last 7 days? ☐ No ☐ Yes

Do you use any other products / drugs that cause photosensitivity? ☐ No ☐ Yes

Are you exposed to the sun on a daily basis? ☐ No ☐ Yes

Do you currently have a sunburn? ☐ No ☐ Yes

Does your skin get blotchy, red, or irritated easily? ☐ No ☐ Yes

Do you plan on spending more time in the sun soon? ☐ No ☐ Yes

Have you recently used a tanning bed/tanning lotions/spray tan? ☐ No ☐ Yes

Have you recently had a chemical, glycolic peel or laser resurfacing? ☐ No ☐ Yes

Is your skin sensitive to soaps/lotions/hydroquinone/skin bleaching agents? ☐ No ☐ Yes

Have you had a tattoo or permanent makeup in the area(s) to be treated? ☐ No ☐ Yes

In the last 6 months, have you had Botox/Fillers in the area(s) to be treated? ☐ No ☐ Yes

Do you have any abrasions, moles or skin irritations in the area(s) to be treated?

___

Please list any skin care products you currently use:

___

Have you had your hair professionally removed before? ☐ No ☐ Yes

If yes, please list areas, methods used and date last removed:

___

___

WHAT SERVICE WOULD YOU LIKE:

Face & Brows:
- ☐ Brow
- ☐ Lip
- ☐ Chin
- ☐ Full face
- ☐ Side bums

Upper body:
- ☐ Full arms
- ☐ Half arms
- ☐ Under arms
- ☐ Back/shoulder
- ☐ Abdomen
- ☐ Chest

Lower body:
- ☐ Full legs
- ☐ Half legs

Other:
- ☐ Brazilian
- ☐ Bikini
- ☐ Full body
- ☐ Other: ________

By signing below, you agree to the following:

I have completed this form truthfully and to the best of my knowledge. I agree to inform the technician of any changes in the above information. I agree to waive all liabilities toward Ili Nani Med Spa, Inc., and any of their associates for any injury or damages incurred due to any misrepresentation of my health history.

______________________	______________________	______________
Client Name (printed)	*Client Name (signature)*	*Date*

_____ Client is Cleared for Laser Hair Removal   Skin Type: _____

______________________	______________
Physician (signature)	*Date*

LASER HAIR REMOVAL

Photo & Video Release Form

I, ________________________________ hereby grant and authorize **Ili Nani Medical Associates Spa** the right to take, edit, alter, copy, exhibit, publish, distribute and make use of any and all pictures, videos and /or audio taken of me to be used in and/or for any lawful promotional materials including, but not limited to, newsletters, flyers, posters, brochures, advertisements, press kits, websites, social media sites and other print and digital communications, without payment or any other consideration.

This authorization shall continue indefinitely and extends to all languages, media, formats and markets now known or later discovered.

I waive any rights to royalties or other compensation arising or related to the use of the photograph or recording.

I understand and agree that these materials shall become the property of **Ili Nani Medical Associates Spa** and will not be returned.

I hereby hold harmless and release **Ili Nani Medical Associates Spa** from all liability, petitions, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons may make while acting on my behalf or on behalf of my estate.

By signing below, I hereby acknowledge that I have completely read and fully understand the above release agreement.

______________________________ ______________

Client Name (printed) : *Date*

______________________________ ______________

Client Name (signature) : *Date*

ILI NANI MED SPA, INC.
(808) 620-0994

LASER HAIR REMOVAL

Cancellation Policy

Our goal is to provide quality care in a timely manner. In order to do so, we have had to implement an appointment/cancellation policy.

Appointments are in high demand, and your early cancellation will give another person the opportunity to have access to timely care. This policy enables us to better utilize available appointments for our clients.

At the time of booking your appointment you will be asked to pay a **50% deposit** that will be credited towards your treatment/s.

Time has been specifically reserved for your appointment, procedure, or treatment. If you need to cancel or reschedule your appointment you must call at least 48 hours prior to your appointment and your deposit will be pushed for a future appointment. However, **providing less than 48 hours notice you will forfeit the deposit**.

If you arrive more than 15 minutes late for your appointment it is considered a no-show and you will be charged the cancellation fee.

We are happy to answer any questions regarding this cancellation policy.

I have read and fully understand the above Appointment Cancellation Policy and agree to be bound by it's terms. I agree to pay the cancellation fee in the event of a missed appointment.

______________________________	______________
Client Name (printed) :	*Date*
______________________________	______________
Client Name (signature) :	*Date*

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FITZPATRICK ASSESSMENT

Client Name: ______________________________ Date: ______________

ANALYSIS	0	1	2	3	4	SCORE
Natural eye color?	Light blue, gray or green	Blue, gray or green	Blue	Dark brown	Brownish black	
Natural hair color? (prior to grey)	Sandy red	Blond	Chestnut, dark blond	Dark brown	Black	
Skin color? (non-exposed)	Reddish	Very pale	Pale with beige tint	Light brown	Dark brown	
Freckles on unexposed areas?	Many	Several	Few	Incidental	None	

GENETIC DISPOSITION TOTAL: ____________

ANALYSIS	0	1	2	3	4	SCORE
What happens when you stay in the sun too long?	Painful redness, blistering, peeling	Blistering followed by peeling	Burns sometimes followed by peeling	Rarely burns	Never had burns	
To what degree to you turn brown?	Hardly or not at all	Light color tan	Reasonable tan	Tan very easily	Turn dark brown quickly	
Do you turn brown within several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always	
How does your face react to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem	

REACTION TO SUN EXPOSURE TOTAL: ____________

ANALYSIS	0	1	2	3	4	SCORE
When did you last expose your body to sun, tanning bed or cream?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than 1 month ago	Less than 2 weeks ago	
Was the area to be treated exposed to the sun, tanning bed or cream?	Never	Hardly ever	Sometimes	Often	Always	

TANNING HABITS TOTAL: ____________

SKIN TYPE SCORE	FITZPATRICK SKIN TYPE
0-7	I
8-16	II
17-25	III
25-30	IV
Over 30	V

TOTAL SKIN TYPE SCORE:	
FITZPATRICK SKIN TYPE	