Healthy Solutions
medical weight loss & spa

CONSULTATION FORM

In order to provide you with the most appropriate laser hair removal treatment, we would appreciate your time in completing the following questionnaire.
All information is strictly confidential.

PERSONAL HISTORY

Name _____ Today's Date _____

Date of Birth ____/___/____ Age _____ Occupation _____

Address _____

City _____ State _____ Zip Code _____

Email _____

Home Phone (_____ Work Phone (_____

CellPhone (_____

Emergency Contact Name _____ Phone (_____

How were you referred to or heard of us? _____

Friend Referral Referring Clients Name: _____

Please check all ethnicities that apply to you:

___Caucasian ___African American ___Hispanic

___Asian ___Middle Eastern/Indian ___Native American/Indian

Today's Treatment Area(s) (select all that apply)

- ☐ Happy Trail
- ☐ Full Arms
- ☐ Lower Arms
- ☐ Upper Arms
- ☐ Full Back
- ☐ Upper Back
- ☐ Lower Back
- ☐ Bikini-Line
- ☐ Brazilian
- ☐ Uni-Brow
- ☐ Cheeks
- ☐ Chin
- ☐ Chest
- ☐ Full Face
- ☐ Ears
- ☐ Hairline
- ☐ Hands & Knuckles
- ☐ Full Legs
- ☐ Lower Legs
- ☐ Upper Legs
- ☐ Upper Lip
- ☐ Neck (Back)
- ☐ Neck (Front)
- ☐ Shoulders
- ☐ Sideburns
- ☐ Stomach/Abdomen
- ☐ Toes & Feet
- ☐ Underarms
- ☐ Nose (Outside only)

Future Desired Treatment Area(s) (select all that apply)

- ☐ Happy Trail
- ☐ Full Arms
- ☐ Lower Arms
- ☐ Upper Arms
- ☐ Full Back
- ☐ Upper Back
- ☐ Lower Back
- ☐ Bikini-Line
- ☐ Brazilian
- ☐ Uni-Brow
- ☐ Cheeks
- ☐ Chin
- ☐ Cleavage/Chest
- ☐ Full Face
- ☐ Ears
- ☐ Hairline
- ☐ Hands & Knuckles
- ☐ Full Legs
- ☐ Lower Legs
- ☐ Upper Legs
- ☐ Upper Lip
- ☐ Neck (Back)
- ☐ Neck (Front)
- ☐ Shoulders
- ☐ Sideburns
- ☐ Stomach/Abdomen
- ☐ Toes & Feet
- ☐ Underarms
- ☐ Nose (Outside only)

Skin typing assessment quiz

Genetic predisposition						**Report Score ↓**
Score ➔	**0**	**1**	**2**	**3**	**4**	
What is the colour of your eyes?	Light blue, grey, green	Blue, grey or green	Blue	Dark brown	Brownish black	……
What is the natural colour of your hair?	Sandy red	Blond	Chestnut, dark blond	Dark brown	Black	……
What is the colour of your skin (non-exposed areas)?	Reddish	Very pale	Pale with beige tint	Light brown	Dark brown	……
Do you have freckles on non-exposed areas?	Many	Several	Few	Incidental	None	……

***Total score for genetic predisposition*:** ……

Reaction to sun exposure						**Report Score ↓**
Score ➔	**0**	**1**	**2**	**3**	**4**	
What happens when you stay in the sun too long?	Painful redness, blistering, peeling	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 colour 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	……
How does your face react to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem	……

***Total score for reaction to sun exposure*:** ……

Tanning habits						**Report Score ↓**
Score ➔	**0**	**1**	**2**	**3**	**4**	
When did you last expose your body to sun (or artificial sunlamp/self-tanning cream)?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than a month ago	Less than 2 weeks ago	……
Did you expose the area to be treated to the sun?	Never	Hardly ever	Sometimes	Often	Always	……

***Total score for tanning habits*:** ……

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

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Skin typing assessment quiz

⬇ Skin Type Score	Skin Type	Features
0-7	I	Caucasian / freckles Always burns and never tans (pale white skin)
8-16	II	Caucasian / freckles Burns easily and tans minimally (white skin)
17-25	III	Darker Caucasian Burns moderately and tans gradually (light brown skin)
25-30	IV	Mediterranean, Asian, Hispanic Burns minimally and always tans well (moderate brown skin)
Over 30	V	Middle Eastern, Latin, light-skinned black, Indian Rarely burns and tans profusely (dark brown skin)
	VI	Never burns (deeply pigmented dark brown to black skin)

Report total skin type score:	.....	**Quiz skin type:**	.....	**Diagnosed skin type:**	.....
Has a consent form been signed? *(pls circle)*	**Yes / No**	**Has an additional pre-treatment compliance checklist been completed?** *(pls circle)*		**Yes / No**	
Assessment conducted by: *(pls print name)*	.....	**Date of assessment:**	...../...../.....		
Name of patient:	.....	**Signature of patient:** *(I attest hereby that I have answered the above to the best of my knowledge)*	.....		

Healthy Solutions
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Consent Form

Please read and initial each statement.
Complete, underline or circle individual selection accordingly.

Initials

- I authorize Healthy Solutions to perform LightSheer®DESIRE™ treatments on me in an effort to improve Hair Reduction / Pseudofolliculitis Barbae /
  Other: _____ _____
- I understand there is a rare possibility of side effects or serious complications including permanent discoloration and scarring. I am aware that careful adherence to all advised instructions will help reduce this possibility _____
- I understand the below list of short-term effects and agree to follow matching guidelines:
  - Discomfort – during the procedure and shortly after, I might experience an itching sensation which degree will vary per hair density, area sensitivity and treatment head used but that does not last long. A mild "sun-burn" sensation may follow for typically up to one hour and will be reduced with application of cooling and soothing creams
  - Perifollicular erythema/oedema – severity and duration of the rash depend on the intensity of the treatment and the sensitivity of the area to be treated. These phenomena may be reduced with application of cooling and/or inflammatory creams
  - Micro-crusting over some areas with very dense and coarse hair – may take 5 to 10 days to flake off and it is important not to manipulate or pick which may otherwise lead to scarring
  - Bruising may rarely occur and may last several days _____
- I understand sun exposure or tanning of any sort is not aligned with the pre and/or post-care instructions and may increase the chance for complications _____
- The procedure as well as potential benefits and risks have been thoroughly explained to me and I have had all my related questions answered _____
- Pre and post-care instructions have been discussed and are completely clear to me _____
- I understand results may vary with each individual. I acknowledge that it is impossible to predict how I will respond to the treatment and how many sessions will be required _____
- I consent to photographs being taken for the purpose of documenting my progress and response to the treatment and be kept solely in my medical record _____
- I consent to photographs being used for medical education or publication with applied discretion and not revealing my identity _____
- I agree to review the following laser pre-treatment compliance checklist along with my Physician and bring accurate and updated data, to the best of my knowledge _____

Skin type of the area to be treated: I □ II □ III □ IV □ V □ VI □		
Natural or artificial sun exposure in the past 3-4 weeks pre-op or the following 3-4 weeks post-op plan	NO	YES
Use of self–tanners or tan enhancer caps within the past 3-4 weeks pre-op plan	NO	YES
Photosensitive herbal preparations (St John's Wort, Ginkgo Biloba, etc…) or aromatherapy (essential oils)	NO	YES: .....
Diseases which may be stimulated by light at 805 nm, such as history of Systemic Lupus Erythematosus or Porphyria	NO	YES: .....
Pregnant or possibility of pregnancy, postpartum or nursing	NO	YES
Inflammatory skin conditions (dermatitis, active acne, etc...)	NO	YES: .....
Presence or history of active cold sores or herpes simplex virus	NO	YES
HIV	NO	YES
Active cancer (currently on chemotherapy or radiation)	NO	YES
Previous skin cancer?	NO	YES
Medical history of keloids	NO	YES
History of livedo reticularis	NO	YES
History of erythema ab igne	NO	YES
Intake of isotretinoin within the past 6 months	NO	YES
Medical history of Koebnerizing isomorphic diseases (vitiligo, psoriasis)	NO	YES: .....
Any known allergy?	NO	YES: .....
Any tattoo and/or dysplastic nevi on requested treatment area that should be protected?	NO	YES
Intake of aspirin or anti-coagulants?	NO	YES: .....
Easy bruising?	NO	YES
Hormonal or endocrine disorders (PCOS or uncontrolled diabetes?)	NO	YES: .....
Previous hair removal procedures on requested treatment area (other IPL/laser, wax, electrolysis, etc…) Within the past 6 weeks?	NO NO	YES: what/when? ..... YES
Previous skin procedures on requested treatment area (Botox, fillers, peels, etc...)	NO	YES: what/when? .....
List of additional current medication taken		

Initials

My signature certifies that I have duly read and understood the content of this informed consent form, and gave the accurate information as to my health condition. I hereby freely consent to LightSheer®DESIRE™ treatments _____

Name of patient (please print) Signature of patient Date

Name of witness (please print) Signature of witness Date

LASER HAIR REMOVAL

Pre-treatment and Post-treatment Patient Instructions

Healthy Solutions Medical Weight Loss | Call (850) 309-0356 | Text (850) 629-0345

Treatment Start Date: _____

Prior to Treatment

1. Avoid the sun/tanning for 4-6 weeks before and after Lumenis LightSheer Desire treatments.
2. You **MUST** avoid plucking, waxing, use a depilatory or undergo electrolysis in the areas you wish to have treated for 6 weeks prior to laser hair removal.
3. If you have had a history of periodical herpes, prophylactic antiviral therapy may be started the day before treatment and continued one week after treatment.
4. Avoid using self-tanning products for 2 weeks prior to treatment.
5. You **MUST** shave the area to be treated 1-2 days prior to your appointment; any hairs not even with your skin cannot be treated. We will gladly help shave the treatment area if requested (additional fees apply).

Intra-Treatment

1. The skin is cleansed and shaved or left with one day of new growth.
2. Safety considerations are important during laser procedure. Protective eyewear will be worn by the client and all personnel during the procedure.

After Treatment

1. Immediately after treatment, there should be erythema (redness) and edema (swelling) at the treatment site which may last 2 hours to several days. The erythema may last up to 2-4 days. The treated area can feel like a sunburn for several hours after, up to the next day sometimes. The application of ice during the first few hours after treatment will reduce discomfort and swelling that may be experienced but we recommend only aloe vera gel after treatment. Rarely, minor epidermal blistering may occur in which case triple antiobotic cream may be applied.
2. Makeup may be used immediately after treatment unless there is epidermal blistering. It is recommended to use **ONLY NEW** makeup to reduce the possibilities of infection.
3. Avoid sun exposure to reduce the chance of hyperpigmentations or darker pigmentation for 1-2 months after treatment. Use sunscreen (SPF 30 or greater) at all times throughout the course of treatment.
4. Avoid picking or scratching of the treated skin. Do not use any other hair removal treatment products or similar treatments (waxing, electrolysis, tweezing or bleaching) that will disturb the hair follicle on the treatment area for 4-6 weeks after the treatment is performed. Shaving may be performed.

5. Call our office with any questions or concerns you may have after the treatment. Return to our office or call for an appointment at the first sign of the return of hair growth. This can mean within 4-6 weeks for the upper body treated and possibly as long as 5-8 weeks for the lower body. Hair re-growth occurs at different rates on different areas of the body. New hair growth will not occur for at least 3 weeks after treatment.
6. Anywhere from 7-30 days after treatment, shedding of the surface hair may occur and this appears as new hair growth. This is **NOT** new hair growth. You can clean and remove the hair by washing or wiping the area with a wet cloth or loofa sponge.
7. After the axillas (underarms) are treated use a powder instead of deodorant for 24 hours after the treatment to reduce skin irritation.
8. There are no restrictions on bathing except to treat the skin gently, as if you had a sunburn, for the first 24 hours.
9. Gently clean area twice daily.
10. Avoid irritants (retinoids etc.) for seven days after treatment.
11. Apply sunscreen for 6 weeks over the treated area.

CANCELLATION POLICY

Healthy Solutions Medical Weight Loss (850) 309-0356 text (850) 629-0345

Canceling an Appointment

Please contact the Healthy Solutions via phone or text **AT LEAST** 24 hours prior to your scheduled appointment date and time to avoid cancellation fees*.

*Cancellation is required 24 hours prior to appointment; failure to cancel within the required time will result in a fee of **$35.00** being charged to the credit card on file. A No Show is considered failure to cancel or failure to show for a scheduled appointment, a fee of **$75.00** will be applied to the credit card on file.

No Shows and Late Cancellations (24 hours+)

Initially, clients who schedule an appointment and simply **DO NOT** show up or cancel within the allotted timeframe of 24 hours will be required to leave a deposit of half (50%) of their scheduled session total in order to reschedule their next appointment.

Client's who prepaid for Package Deals

Clients who have prepaid for package deals who are No Shows or have Late cancellations for their scheduled appointments will **automatically** be deducted the cancellation fee from the package balance and must pay the balance in order to continue treatment.

New Clients

If a new client fails to cancel or reschedule their appointment date within the 24 hour time frame they will forfeit **ALL** limited-time pricing offers, monthly special promotions, discounts or coupons**.**

We reserve the right to refuse appointments to any client who has demonstrated disregard of our cancellation policy.

I understand the cancellation policy and agree to its terms.

Client Signature _____ Date _____

Client Name (Please Print) _____

DEBIT/CREDIT CARD Authorization Form

Cardholder Name (as it appears on card) _____

Credit Card Number (list all numbers) _____-_____-_____

Expiration Date _____

CVV* _____

*CVV is the last 3 digits on the back of your card.

◯ **Master Card** ◯ **Visa** ◯ **Discover** ◯

◯ Check circle if same as **Home Address**

Credit Card Billing Address_____

City_____ State _____ Zip Code _____

I agree to be charged in the amount indicated above via debit/credit card if I fail to follow the cancellation policy as stated by terms set by

Healthy Solutions Medical Weight Loss.

Cardholder Signature _____ Date_____