

**HAIR TODAY GONE TOMORROW
CLIENT INFORMATION**

Date: _____ Marital Status S M D W

Client Name: _____ Date of Birth _____ Age ___M ___ F ___

Address: _____ City: _____ State: _____

Zip Code: _____ Home Phone: (____) _____ Work Phone: (____) _____

Best number and time to reach you: _____

Telephone number where we can leave a message: (____) _____ Cell Phone:(____) _____

E-Mail Address: _____

Would you like to receive emails from HTGT regarding sales and promotions? YES _____ NO _____

Have you had epilation before? _____ If yes, what type? _____ Body part: _____

What color is the hair you would like removed? _____ Is color natural, tinted or bleached? _____

Do you have any cosmetic tattooing? _____ If yes, where? _____

Do you regularly take any photosensitive medication or herbal supplements? _____. If yes, please list:

Please list any other medication or herbal supplements taken regularly. _____

Do you use any blood thinning or anti-coagulant medication? If yes, please list. _____

Are you currently taking Accutane? _____ within the last 3 months? _____

Are you using any products that contain AHA, Retinoids, or Retinols? _____

Are you allergic to any medication? _____ If yes, please list _____

Have you ever had any of the following? Diabetes _____ Bleeding disorders _____ Phlebitis _____

Thrombosis _____ Sun allergies _____ Psoriasis _____ High blood pressure _____ Keloid or thick scarring _____

Thyroid condition _____ Hormone imbalance _____ Skin pigment changes _____ Herpes breakout _____

Are you pregnant? _____

When was the area you want treated last exposed to the sun? _____ Tanning booth? _____

Artificial tanning preparations? _____

If you expose your skin to the sun for one hour at noon, without sunscreen, what would be the result?

Check all of the following that applies to you.

Always burn, never tan _____ Always burn, sometimes tan _____

Sometimes burn, always tan _____ Never burn, always tan _____

Asian, Hispanic, Mediteranean _____ African American _____

Please circle areas you are interested in treating: Face Chest Abdomen Bikini Genitalia Brazilian Arms
Legs Underarms Back Shoulders Buttocks Full Body Other _____

How did you hear about us? _____

Client Signature _____

Date _____

* Are you interested in Care Credit Financing? Yes _____ No _____