BEAUTYFIXX
BeautyClinic

# IPL Hair Reduction Consultation Form

**Name:** _____ **Date:** _____

Date of Birth: _____

Telephone: _____

Occupation: _____

Email Address: _____

Contact in case of emergency _____

What areas of the body do your require IPL Hair Reduction

_____

Skin colour without sun exposure: white fair medium olive dark

Do you tan easily: yes no

Do you sunburn quickly: yes no

| | | |
|---|---|---|
| Have you had significant sun exposure in the last 2 weeks? | Yes: _____ | No: _____ |
| Do you have tattoos or permanent makeup in areas to be treated? | Yes: _____ | No: _____ |
| Do you have fake tan in the treatment area? | Yes ____ | No: _____ |
| Are you currently pregnant or trying to conceive? | Yes: ____ | No: _____ |
| Have you had IPL Previously? | Yes: ____ | No: _____ |

**Details** _____

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**Have you ever experienced or been treated with the following?**

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Epilepsy | | | Photosensitizing medication | | |
| Pacemaker | | | Roaccutane/ acne medication | | |
| Skin Cancer | | | Cancer – current treatment | | |
| Cold Sores | | | Heart condition | | |
| Hormonal Condition | | | Recent vaccination | | |
| Eczema, dermatitis/ psoriasis | | | Allergies | | |
| Lack of sensation or heat | | | Skin Disorder | | |
| Retinol facial products | | | Other medical condition | | |

*If yes* to any of the above, please explain and include dates / details:

_____

**Have you recently had any of the following in the treatment area?**

| | | | |
|---|---|---|---|
| Chemical Peel | Yes / No | Botox/Injectables | Yes / No |
| Micro-Dermabrasion | Yes / No | Resurfacing or Fractional Laser | Yes / No |
| Implants | Yes / No | Surgery | Yes / No |
| IPL | Yes / No | Dermal Rolling | Yes / No |

*If yes*, to any of the above, please explains and includes dates / details:

_____

**What Skincare products are you currently using on the treatment area?**

_____

**Please list all CURRENT medications:**

_____

**Please list all CURRENT vitamin supplements, herbal remedies:**

_____

**Client Consultation Form – Informed Consent**

**Please sign after reading Full IPL Hair Reduction information document**

I understand that the BeautyFixx Intense Pulsed Light technology is used for reduction of unwanted hair and that clinical results will differ in different people, according to health, life style, skin and hair type as well as the medical condition of the client.

The purpose of the treatment is to achieve cosmetic improvement, by reducing hair growth

I _____duly authorize staff of BeautyFIXX or other specially trained associate technicians to perform hair reduction using IPL methods.

**I have been advised of the following possible side effect and risks of Pulsed Light treatments and accept the risk of any potential side effects:**

| | | **Sign** |
|---|---|---|
| 1 | IPL is a very popular and largely successful treatment with certain general expectations. However due to the variables in each client, an exact result cannot be predicted and I acknowledge that no guarantees have been made to me as to the results that will be obtained. Skin colour, hair thickness, hormones, skin sensitivity, undiagnosed medical conditions can affect the results. If no results are visible after 3 treatments we will recommend to discontinue the program. Refunds are not offered | |
| 2 | Common side effects of the area treated can include temporary redness, sensitivity, swelling, hives, itchiness and tingling sensation. Temporary darkening of freckles | |
| 3 | Other less common side effects can include colour changes such as hyper-pigmentation (brown/ red discoloration) or hypo-pigmentation (skin lightening) and burns | |
| 4 | Hormonal conditions (menopause, adolescence, pregnancy) can cause hairs to be more resistant to treatment and may take longer to treat than average. A very rare side effect in those with hormonal disorders such as polycystic ovary syndrome is an increase in hair growth surrounding the treatment site. | |
| 6 | Skin must be protected from any UV exposure for 4 weeks before and 2 weeks after treatment. Unprotected sun exposure in the weeks pre and post treatment increases chance of hyper / hypo pigmentation, sunburn and burns during treatment | |
| 8 | I have received written client information / after care information and agree to follow the aftercare instructions | |
| 10 | My questions regarding this procedure have been answered to my satisfaction. I accept all risks and outcomes of treatment. | |
| 11 | I consent to photographs for the purpose of monitoring response to therapy. | |

**Client Signature:** _____ **Date:** _____

**Therapist Signature:** _____ **Date:** _____