SKINCEUTICALS

Hydration level (if tested)

Skin scan – use drawing to show hyperpigmentation and issues

Products/samples given	Date	Products
First visit Second visit: Third visit: Fourth visit:		

LIFE STYLE HISTORY

PH of skin

Name: **Telephone Number:**

Are you taking medication What type?	Yes / No	Allergic & ultra sensitive skin/AHA intolerance (*no AHA products*)	Yes / No
Are you pregnant or lactating *(cannot prescribe Retinol or Gel Peels)*	Yes / No	Sunburn	Yes / No
Are you suffering from acne? Grade of acne – 1, 2, 3 or 4 Reason for acne: Hormonal/diet related/genetic/other	Yes / No	Rosacea *(do not carry out peels if active – avoid AHAs)*	Yes / No
Recent Botox or collagen injections	Yes / No	Dermatitis *(do not prescribe skin firming cream)*	Yes / No
Have you used Roaccutane in last 6 months *(cannot prescribe Retinol or Gel Peels)*	Yes / No	Are you allergic to Arnica (Foaming Cleanser), Yeast & tomatoes (lip repair & Skin Firming Cream)	Yes / No
Have you used Retin A/Retinova in last six weeks *(cannot prescribe Retinol or Gel Peels)*	Yes / No	Micropigmentation *(do not use Antioxidant lip repair on lips)*	Yes / No
Do you smoke	Yes / No	Keloid or Pigmented Scarring	Yes / No
Have you any sun damage (UVA)	Yes / No	Seborrhoea	Yes / No
Are you taking antibiotics	Yes / No	Surgery or any trauma	Yes / No
Herpes	Yes / No	Stress or Anxiety	Yes / No
Recent scarring or Surgery (12 months)	Yes / No	Recent Medical treatment, radiation, laser Cryo, electro or any injections	Yes / No
Eczema *(cannot prescribe skin firming cream or phyto+ if pollen related eczema)*	Yes / No	**What brands of skincare currently using:**	
Have you any cuts or skin abrasions	Yes / No	Cleanser/toner	
Recent Permanent hair dying *(gel peel could carry any hair dye into skin)*	Yes / No	Serum	
Lesions of malignant pigmented areas	Yes / No	Exfoliant	
Warts	Yes / No	Masks	
Chronic / Serious Illness	Yes / No	Moisturisers	
Psoriasis	Yes / No	Eye gel or cream	
Are you going on Holiday/have you been on holiday? (can't do Gel peels for 4 weeks either side)	Yes/No	Sun Protection	
Are you allergic to aspirin? **(cannot carry out salicylic peel)**	Yes/No	Additional comments	

Signature of Client _____

Signature of Therapist _____

Date: _____

SKINCEUTICALS

Consent Form (Gel Peels)

This form is designed to give you the information you will need to make an informed choice as to whether or not to undergo a Glycolic/Lactic or Salicylic/Mandelic peel. If you have any questions, please do not hesitate to ask. Although the peels are effective in most cases, no guarantee can be made that a specific patient will benefit from the treatment.

- The Glycolic/Lactic peel is recommended for Photodamaged skin; Rough texture; Dry skin; Aging skin.
- The Salicylic peel is recommended for Problematic skin, Sensitive skin, Aging skin, Photo-damaged skin and Hyperpigmentation

What are the possible side effects and complications of a Gel Peel treatment?

1) TINGLING. You may feel some discomfort when treatment occurs. If the treatment is too uncomfortable, please indicate this to your therapist, who will remove the product from your skin. You may also experience "hot spots" and/or crusting due to deeper penetration in specific areas

2) HEADACHES: you may experience headache, nausea or dizziness during the treatment – although recorded cases are rare.

3) HYPERPIGMENTATION: Hyperpigmentation may occur in some cases. We absolutely insist that sunscreen is used straight after the peels and during the treatment period to ensure that this does not happen.

4) PLEASE CONFIRM THAT YOU HAVE NONE OF THE FOLLOWING CONDITIONS BEFORE AGREEING TO GO AHEAD WITH THE PEEL OR THAT YOU ARE USING NONE OF THE BELOW-MENTIONED PRODUCTS/TREATMENTS:

Pregnancy	□ Yes	□ No
Use of Roaccutane	□ Yes	□ No
Coldsores (Herpes outbreak)	□ Yes	□ No
Acne (only applies if having Glycolic peel)	□ Yes	□ No
Plastic surgery in last 6 months	□ Yes	□ No
Allergy to Aspirin	□ Yes	□ No
Use of Retin A/Retinova/Retinol products	□ Yes	□ No

Further Considerations for Consent

1) I acknowledge that no guarantee has been given to me as the condition of the complexion, skin pore size, wrinkle reduction, or the amount or percentage of improvement expected following the treatment.

2) I acknowledge that for many conditions, more than one Gel Peel may be required in certain areas to achieve the desired result. In fact, a course of a minimum of 6 is recommended for best results.

3) I acknowledge that no guarantee or assurance has been made by anyone regarding the procedure that I herein request and authorize.

4) If I know or suspect that I may be pregnant, I will inform the operator prior to treatment.

Consent

By signing below, I acknowledge that I have read the foregoing informed consent regarding the Gel Peel and I feel I have been adequately informed regarding the associated risks. I hereby give consent to the Gel Peel procedure to be performed by_____.

Date: _____ Time: _____

_____ _____

Client's Signature **Parent or Guardian (if client is under the age of 18)**