Plasma Fibroblast Skin Tightening & Lifting Intake Form

Client Name		Date	
E-mail		Phone	
Address			

Medical Background

Check all that apply (past and present)

☐ *Anemia*	☐ *Epilepsy*	☐ *Bleeding Disorder*	☐ *Hypertension*
☐ *Cancer*	☐ *Alopecia*	☐ *Recent Surgical Incision*	☐ *Hepatitis/HIV/AIDS*
☐ *Keloid Scarring*	☐ *Eczema, Rosacea, Other Skin Disorders*	☐ *Cataracts*	☐ *Diabetes*
☐ *Transdermal Drug Delivery System*	☐ *Pacemaker/Other Electronic Device Implant*	☐ *Thyroid Disorders/Disease*	☐ *Hives, Herpes, Shingles*
☐ *Laser Eye Surgery*	☐ *Transplant*	☐ *Plastic/Bone Cement/Metal Implants*	☐ *Accutane Usage Past Year_____ Other _____*
☐ *Autoimmune Disease*	☐ *Insulin Monitor*	☐ *Heart/Kidney/Live Disease*	☐ *Infection*
☐ *Anticoagulants (Blood Thinners)*	☐ *Asthma, COPD, Emphysema*	☐ *Hemophilia/Blood Disorder*	☐ *Hyper/Hypo-pigmentation*
☐ *Botox Injections, past 2 weeks*		☐ *Allergy to topical numbing cream*	

☐ *Other Medical Conditions:*

☐ *Current Medications (including aspirins or anticoagulants):*

☐ *Recreational Drug Use:*

☐ *Pregnant/Breastfeeding:*

☐ *Birth marks, port wine stains, cosmetic tattoos (include location):*

☐ *Allergies (please list all/any):*

By signing below, you agree to the following:
I have completed this form to the best of my ability and knowledge and agree to inform my practitioner of any changes to the information listed on all pages of this client intake form. I have been informed of an understand the contraindications to the requested treatments and agree that I do not have any conditions that would make the requested treatment unsuitable. I will inform my practitioner of any discomfort I may experience at any time during my treatment to allow them to adjust accordingly. I agree to waive all liabilities toward my practitioner and Simply You/Shelly Chilton for any injury or damages incurred due to my misrepresentation of my health history.

Signature	**Date**	**Professional Signature**	**Date**