Name: _____ Phone: (____)_____ Mobile Provider: _____

Address: _____ City_____ State_____ Zip_____

E-mail: _____

Referred by: _____Phone (_)_____

In case of emergency: _____Phone (_)_____

Occupation: _____How did you hear about us?_____

Gender: ☐ Male ☐ Female DOB: _____

Physician, Dermatologist or Plastic Surgeon: _____

Please take a moment to read the following information. Have you ever experienced a BioMat session or a CRT Session? _____ If you have a specific medical condition or specific symptoms, your session may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

YES	NO	SYMPTOMS
☐	☐	Do you frequently suffer from stress? Do you experience frequent headache? Backaches?
☐	☐	Do you have diabetes?
☐	☐	Are you pregnant?
☐	☐	Are you wearing contact lenses?
☐	☐	Are you on Accutane or other similar medication? Do you have an autoimmune disease or a contagious disease? Are you on blood thinners – Heparin, Coumadin, Warfarin, etc.? Do you have cancer or on post-cancer treatments? Do you have cold sores or fever blisters without pre-medication? If yes, when was your last break out? Are you on Cortisone or steroid injections?
☐	☐	Do you have high blood pressure?
☐	☐	Any head or neck injuries in the last 2 years? Do you have tension or soreness in a specific area?
☐	☐	Have you had cosmetic injections, filler or implants? When? _____ Do you have enlarged or painful glands? Have you had facial waxing services within 7-14 days? Do you have irregular, pigmented moles, warts or growths, unidentified facial growth or marks?
☐	☐	Do you have keloids, pigmented scars, icepick scars, or new scar tissue? Have you had laser procedures, chemical peels, dermabrasion, or microdermabrasion?
☐	☐	Have you had any recent surgical or dental procedure? Do you have rosacea, or telangiectasia or couperose? Are you on Retin-A or Retinol? Do you have skin abrasions or lesions? Do you have stage III or IV acne? Have you used any skin-lightening or bleaching agent? Do you have sunburn? Do you have swollen or infected tonsils? Do you have thyroid conditions? Are you under medical care for an existing or suspected condition or disease? Do you have a viral infection or influenza? Do you have other medical condition(s), or are you taking any medications I should know about? Do you have any allergies? If so, please list them.

Please list any known allergies and if you answered **YES** to any of the above questions please explain:

_____

_____

My interest in skincare treatment is primarily for (i.e. skin rejuvenation, acne, hyperpigmentation, scarring, etc.)

_____

Specify your areas of concern (i.e. eyes, forehead, etc.)

_____

CLIENT CONSENT FORM

(Initial each acknowledgment line below)

1. I acknowledge that I have not used Accutane or any medication for the same purpose during the last 12 months. _____ *(initial here)*
2. I acknowledge that if I have ever had a cold sore or fever blisters, I should consult with my physician or pharmacist for a pre-use medication to help avoid a possible breakout. That medication should be used each day for two days before, same day, and two days after any aggressive facial exfoliation treatment. _____ *(initial here)*
3. I acknowledge that there is no guarantee that dark discoloration of skin will be reduced or fade. Pigmentation may improve or darken with successive treatment. I acknowledge the need for proper skin care home regimen. _____ *(initial here)*
4. I acknowledge that my skin might experience temporary irritation, tightness, redness, or slight swelling which usually dissipates within 72 hours depending on skin sensitivity. _____ *(initial here)*
5. I have disclosed my history of allergies above. _____ *(initial here)*
6. I acknowledge that if I am allergic to one or more of the ingredients in the products used, I may experience allergic reactions. _____ *(initial here)*
7. I acknowledge that if I fail to use a minimal sunscreen (SPF 30) and follow the discretion for use, I am more susceptible to sunburn, sun damage and hyperpigmentation. I should avoid excessive sun exposure, especially between 10am – 2pm. _____ *(initial here)*
8. I acknowledge that this treatment is strictly an elective cosmetic procedure and that no medical claims have been expressed or implied. _____ *(initial here)*
9. I acknowledge that I should avoid use of aggressive exfoliation, waxing, and products containing acids that are not part of the recommended take-home regimen for 2-4 weeks following the treatment. _____ *(initial here)*
10. I acknowledge that I should avoid use of Retin-A type products for a period of time recommended by my physician and/or skincare practitioner during and following the treatment. _____ *(initial here)*
11. I acknowledge that I am not pregnant/lactating. _____ *(initial here)*
12. I hereby agree to have the treatment performed and agree to follow all pre and post treatment instructions. _____ *(initial here)*
13. I acknowledge that I have answered all questions truthfully and completely. _____ *(initial here)*
14. I consent to a Cranial Release Technique performed by a Certified CRT Practitioner. _____(initial here)
15. I release Edge Systems, Therapeutic Touch Aesthetics and Bodywork, LLC, the facial specialist, the CRT Practioner, the management, and the staff from any and all liability associated with any injuries and/or current or future conditions resulting from the skincare products or procedures. _____ *(initial here)*
16. I consent to the use of my before, during and after facial procedure photographs for education, promotion or advertising purposes. My name will not be used to identify these photographs without my written approval. _____ *(initial)*

By signing below, I certify that I have read and fully understood the contents of this consent form, and that the information I provided above are complete, accurate, and up-to-date to my knowledge.

Client Signature: _____ Date: _____

Specialist Signature:_____ Date: _____