SKINCARE INTAKE FORM

All information is confidential

Please complete the following information as thoroughly and honestly as possible. Some of the questions that follow may seem unrelated to your condition, however, they may play a role in treatment. We would like to make your service as pleasant and comfortable as possible. If at any time you have questions regarding your session, please let your let your therapist know.

Name *(Last)* *(First)* *(MI)* *Date of Birth*

Home Address

City State Zip

Phone *(Day)* *(Evening)* *(Cell)*

Occupation

If we may contact you by e-mail, please provide your e-mail address:

MEDICAL

Are you currently under the care of a physician? ☐Yes ☐No

If yes, who is your physician? ____________________

Please take a moment to carefully read the following list of conditions and questions below and check any that have affected your health either recently or in the past. A referral from your primary care provider may be required prior to service being provided.

- ☐Weight Gain
- ☐Fluid Retention
- ☐Difficulty relaxing
- ☐Heart Condition / Pacemaker
- ☐Tension Headaches / Migraines
- ☐Skin Rashes
- ☐Cardiac or Circulatory Problems
- ☐Diabetes
- ☐Dry Skin
- ☐Blood Clots
- ☐Lack of normal skin sensation
- ☐Multiple Sclerosis
- ☐Insomnia
- ☐Wearing contact lenses
- ☐Hormonal Therapy
- ☐Diabetes
- ☐High level of stress
- ☐Migraines or frequent headaches
- ☐Arthritis or Joint Swelling
- ☐HIV Positive
- ☐Lethargy
- ☐Osteoporosis
- ☐Thrombosis/Phlebitis
- ☐Herpes Virus (i.e. cold sore, fever blister)
- ☐Cellulite
- ☐Thyroid (over or under active)
- ☐High or Low Blood Pressure
- ☐Epilepsy or Seizures
- ☐Sinus Infection
- ☐Muscle Conditions/Pain/Cramps
- ☐Back Pain
- ☐Fibromyalgia
- ☐Varicose Veins
- ☐Hypoglycemia
- ☐Hepatitis

☐Recent Illness ____________________

☐Contagious Conditions ____________________

☐Pregnant Trimester : ______________________________

☐Skin Cancer Where/When: ______________________________

☐Metal implants Location: ______________________________

☐Surgeries What/When: ______________________________

☐Accidents ______________________________

☐Any other health concerns ______________________________

☐Cancer ______________________________

☐Taking Medications ______________________________

Are you allergic to any cosmetic ingredient, medication or food? Please List:______________________________

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Rate your level of stress on a scale of 1-10 (10 being highest) ______________________________

Does stress affect any of the following? ☐Skin ☐Digestion ☐Breathing ☐Sleep ☐Health ☐Muscle Tension

What do you do to relieve stress?______________________________

What type of and how frequently do you exercise? ______________________________

SKIN

Which concerns apply to your skin? Please check all that apply:

☐Uneven Skin Tone	☐Brown Spots (Hyperpigmentation)	☐White Spots (Hypopigmentation)
☐Acne	☐Clogged Pores	☐Blackheads / Whiteheads / Milia
☐Excessive Oiliness	☐Bumps Under Skin	☐Scarring
☐Fine Lines/Wrinkles	☐Dryness	☐Sensitivity/Redness
☐Skin Laxity	☐Unwanted Hair	☐Visible Capillaries/Blood Vessels

☐Please List Other Concerns:______________________________

Please check the skincare products you currently use and their brand names:

☐Cleanser ________	☐Serum________	☐Eye Cream ________
☐Toner ________	☐Moisturizer/Day________	☐Moisturizer/Night________
☐Exfoliant ________	☐Retinol/AHA/Glycolic ________	☐SPF________

☐Other please list: ______________________________

Please check the prescription medications you are currently using:

☐Accutane ☐Differin ☐Retin-A, Renova, Kinerase ☐Tazorac ☐Antibiotics (Oral or Topical)

☐Other please list: ______________________________

In the past 30 days, please list all professional facial or dermatology services you have received (i.e. Chemical Peel, Microdermabrasion, Laser, BOTOX®, other cosmetic injectibles, etc.): ______________________________

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AUTHORIZATION AND CONSENT FOR Microcurrent Facial Toning and Microdermabrasion

Please read this authorization carefully and aknowledge your understanding by signing your name in the space below.

To The Patient. You have the right, as a patient, to be informed about your condition and the procedure to be used, indicating risks and benefits, so that you may make the decision whether or not to undergo the procedure. This authorization and consent form is an effort to make you better informed. To that end, we encourage you to ask our staff any questions you may have. You are also encouraged to conduct your own research or consult with your own health care provider if you have additional questions.

Procedures, Possible Side Effects and Limitations.

Microcurrent Facial Toning is a non invasive, low level of current that mirrors the body's own natural electrical impulses that stimulates ATP (Adenosine Triphosphate), the body's healing and rejuvenating properties. When used in conjunction with specialized products and manual manipulations, these tiny microcurrent impulses encourage your body's currents. The signs of aging are greatly reduced, while skin tone and elasticity are dramatically improved. For the best results, we recommend a series of 10 treatments during a 5 week period (i.e. two times per week). Following a series of 10 treatments, it is recommended to have an Ultimate Age Defying Facial once per month to maintain optimal results.

Microcurrent treatments cannot be performed for any of the following reasons: if the client is pregnant and/or has serious health conditions (cancer, heart problems, etc.) or suffers from any of the following contra-indications: epilepsy, seizure, thrombosis or phlebitis, all infectious illnesses, any drug or topical application causing thinning of the skin (Retin A, Accutane, etc.). The treatment also cannot be performed if the client has: cardiac pacemaker, metal implants anywhere in the face, or is using an anabolic steroid.

Microdermabrasion works by removing the superficial layer of skin called the stratum corneum. This procedure uses a combination of pressurized abrasive particles applied to the skin and vacuuming the used particles and skin debris with controlled suction. I understand that it may take multiple treatments to achieve the desired effects.

This procedure may cause side effects. The side effects listed here are merely examples and are not intended to be an exhaustive list. Every person is different and there is no guarantee that more severe side effects will not occur. Of the observed side effects, the most common are listed. There may be temporary redness and skin tightness that may last up to 24 hours. There may be mild discomfort during the procedure. Please notify the esthetician if you have any pain. Bruising and swelling may result. Skin infections sometimes occur, but are generally more likely if there is an open wound. Changes in skin color are rare because only the upper skin is removed where there is no pigment. However they may occur. Scarring may result, but may be minimized if you follow all post-operative instructions carefully. Protective eyewear (shields) will be provided. It is important to keep the shields on during the treatment to protect your eyes from accidental particle exposure. Although uncommon, you may have temporary lines or streaking of the skin that could last for several days. If you have a history of oral herpes simplex, a reactivation of this condition may occur over the treated area.

Clinical & Superficial Peels are designed to improve the texture and appearance of your skin. Peels should not be performed on patients with active cold sores or warts, skin with open wounds, sunburn, excessively sensitive skin, dermatitis or inflammatory rosacea in the area to be treated. Inform your esthetician if you have history of herpes simplex. You should also not have a peel treatment if you have history of allergies, rashes, skin reactions and extremely sensitive skin. Peels are not recommended if you have taken Accutane ™, or received chemotherapy or radiation therapy within the past year. Salicylic peels should not be performed on patients with an allergy to salicylates (i.e. aspirin) and should not be administered to pregnant or breastfeeding (lactating) women. Side effects from peels listed here are merely examples and are not intended to be an exhaustive list. Every person is different and there is not guarantee that more severe side effects will not occur. Of the observed side effects, the most common are listed. Swelling of the face and/or treated area may occur. The epidermis may turn red (resembling sunburn) blister and/or crust before it heals. The peeling is usually one day to one week, but may vary depending on the individual. There may be a potential risk of developing pigmentation changes in the area treated, which may or may not be temporary. Some patients have an allergic reaction to the peel or creams applied afterward which, in extremely rare cases, may lead to scarring. There may be some degree of discomfort during and after the procedure (stinging, pinpricking sensation, hotness, and tightness). The foregoing list is not intended to be a complete or exhaustive list of all possible problems or complications, which may arise as a result of the clinical procedure (s). Should one or more of the foregoing complications arise, please notify the office immediately.

Demarcation is a difference in color, texture, or pigmentation that may occur at the junction between the treated and non-treated skin areas. This is unusual with epidermal procedures. Existing Blemishes or moles, blood vessels (telangiectasias), freckles and sun spots may become more obvious and darker since layers of dead skin have been moved. Eye Injury caused by chemicals getting into the eye, scarring and vision disturbances may occur. Protective safety goggles are recommended to be worn by you, the patient, while chemicals are being used during all clinical procedure (s). Milia may occur, but will usually disappear quickly. Infection is extremely unlikely, but may happen. An outbreak of herpes may occur in affected individuals (if you are prone to cold sores, ask your physician for medication). Hair Growth: If the demaplaning phase of the SkinCeuticals Micropeel is administered, hair is expected to grow back blunt-ended. New hair will not appear darker and denser. However, I do understand that hormonal imbalance that may be present within my anatomical system can alter the normal hair growth patter and cause a darker and denser restoration process. In General: Any and all of the risks and complications can result in additional surgery, hospitalization, time off work and expenses to you. Early detection and treatment may minimize future complications.

Before subjecting yourself to any clinical procedure (s), read carefully the following statements. After you have read each statement, please *initial* each respective statement in the space that has been provided.

________ The __________________________________ procedure (s) has been explained to me in detail by the esthetician. For optimal results, I understand a homecare regimen is needed to enhance the results of a clinical peel.

________ I understand the _______________________________ is a skin rejuvenation treatment. I may need several administrations of this procedure in order to achieve my best results.

________ I understand the _______________________________ need not be administered by a physician. I am also comprehend that, in addition to receiving formal training, the esthetician who administers the treatment has had his/her skills reviewed and endorsed by the supervising or attending physician.

________ I understand that it is extremely important to strictly follow all homecare regimen instructions when striving for optimal results.

________ I understand that if I experience any adverse side effects that appear to be attributable to my use of homecare regimen products, I would discontinue use of the product and notify the office.

Waxing is a procedure to remove unwanted hair. Warm to hot wax is applied to the skin, and a strip of cloth or paper is pressed into the preparation. The strip is then quickly pulled away, taking hairs with it. Of the observed side effects, the most common are listed. Taking antibiotics may make skin more sensitive and susceptible to some skin lifting. Please be aware that waxing may cause inflammation, welts, hives, reddening or small breakouts due to bacteria being pulled to the surface along with the hair or sensitivity or allergy to the wax. This is usually not severe and may subside within a few days. If you have a reaction, apply a topical antibiotic such as Neosporin, and apply ice, stay out of the sun and use SPF 30 sun block.

Authorization. I hereby authorize PRO Sports Club, its employees, and agents to perform a Microcurrent Facial Toning and/or Microdermabrasion procedure on me. I fully understand this procedure has limited applications. I am aware the practice of medicine and surgery is not an exact science and I acknowledge reputable practitioners cannot properly guarantee quality and/or results or freedom from complications, and I have not received such guarantees. I acknowledge I have had the opportunity to ask questions, and I fully understand the Microcurrent Facial Toning and Microdermabrasian procedures. These procedures are generally considered cosmetic, and may not be covered by insurance. I understand I am responsible for all costs of the procedure and related treatments.

Client Certification:
I hereby certify I do not have any of the foregoing conditions, devices or implants as described above. Initials: __________

WAIVER AND RELEASE OF LIABILITY

1. RELEASE OF LIABILITY – To the maximum extent allowed by law, I, the undersigned ("I"), agree to waive and release any and all claims, suits or related causes of action against Professional Recreation Organization, Inc., its owners, officers, employees, or agents (collectively "PRO Sports Club"), for negligence, injury, loss, death, costs, or other damages to me, my heirs or assigns, while on the premises of PRO Sports Club or participating in any off-site PRO Sports Club program or activity.

2. ASSUMPTION OF RISK – I understand and acknowledge there are risks involved with spa services and treatments. I have had the opportunity to ask questions regarding these risks and other possible complications. I understand any false or misleading information I have given may lead to undesired results and complications and hereby waive PRO's liability if such results or complications occur. I further understand my failure to follow post care instructions may also lead to undesired results, complications or effects and hereby waive PRO's liability if such results or complications occur. In consideration for PRO performing this procedure, I agree I will assume the risk and full responsibility for any and all injuries, losses, or damages, which might occur to me and/or my family while undergoing this procedure or side effects that may be experienced after the procedure is performed. I understand that the service providers do not diagnose illness, disease, or any other physical or mental conditions. The providers also do not prescribe medical treatment or pharmaceuticals, nor do they perform any spinal adjustments. Spa services are not a substitute for medical examinations and diagnosis. It is recommended that I see a physician for any physical or mental ailment that I might have. Any sexual misconduct exhibited by the Client will result in immediate termination of the session, and the client will be liable for payment of the scheduled appointment. If for any reason I am uncomfortable, I may ask

the therapist to cease the massage and the therapist will end the session. If I cancel, reschedule, or skip an appointment without 24 hours notice, I agree to forfeit the full session fee.

3. INDEMNIFICATION – I agree I will indemnify, defend and hold PRO Sports Club harmless, to the maximum extent allowed by law, from negligence, injury, loss, death, costs or other damages to me, my heirs or assigns, or third parties for claims, suits, or related causes of action asserted against PRO Sports Club arising from my conduct and/or my family's conduct while on the premises of PRO Sports Club or participating in any off-site PRO Sports Club program or activity.

4. APPLICATION – I agree that this Waiver and Release of Liability ("Release") shall apply to each visit I make to PRO Sports Club, including future visits, regardless of any date of issuance or expiration date on the Guest or Permanent membership card, and regardless of the date that this form is signed below.

5. AGREEMENT TO COMPLY WITH RULES – I agree to, and will comply with, PRO Sports Club's Policies as posted at www.proclub.com and, if I am a PRO Sports Club member, any specific usage restrictions as defined on the Membership Agreement. I acknowledge PRO Sports Club's Policies are subject to change at the sole discretion of PRO Sports Club.

6. BINDING ON OTHERS – This Release shall bind the members of my family and my spouse or registered domestic partner, if I am alive, as well as my estate, family, heirs, administrators, personal representatives or assigns if I am deceased and shall be deemed as a "Release, Waiver, Discharge and Covenant" not to sue PRO Sports Club.

7. SEVERABILITY – I agree that the purpose of this Release is that it shall be an enforceable release of liability and indemnity as broad and inclusive as is permitted by Washington law. I agree that if any portion or provision of this Release is found to be invalid or unenforceable, then the remainder will continue in full force and effect. I also agree that any invalid portion will be modified or partially enforced to the maximum extent permitted by law to carry out the purpose of the Release.

8. APPLICABLE LAW, FORUM & ATTORNEY'S FEES – This Release is governed by and shall be construed in accordance with the laws of the state of Washington, without any reference to its choice of law rules. I agree that any dispute arising from this Release or in any way associated with PRO Sports Club shall be brought only in the Superior Court of King County, Washington, or in the U.S. District Court for the Western District of Washington, and I agree to the jurisdiction and venue of those courts for any such dispute. In any litigation in which the validity or enforceability of this Release is contested, I agree that the substantially prevailing party will be entitled to receive all attorney's fees and costs from the party contesting the validity of this Release.

9. INTEGRATION – This Release, in conjunction with the Membership Agreement, encompasses the entire agreement of the parties, and supersedes all previous understandings and agreements between the parties, whether oral or written. I acknowledge that no oral representations, statements or other inducements to sign this Release have been made apart from what is contained in this document.

I certify that I have read and fully understand the above paragraphs, that I have had sufficient opportunity for discussion and to ask questions, and that I hereby consent to the procedure described above. I have fully informed myself of the contents of this release by reading it before signing it. By my signature below I understand and agree to the above terms and conditions. All of the above information is true and accurate to the best of my knowledge. I take full responsibility for alerting my practioner to any physical or mental condition which would affect my service or results. I am aware of and will inform my practitioner(s) of any changes in my health. I understand that these services do not constitute as medical treatment.

MAXIMUM LIABILITY. PRO SPORTS CLUB'S MAXIMUM AGGREGATE LIABILITY TO PATIENT RELATED TO OR IN CONNECTION WITH THE PROCEDURE PERFORMED BY PRO SPORTS CLUB, ITS EMPLOYEES, OR AGENTS WILL BE LIMITED TO THE TOTAL AMOUNT PAID TO PRO SPORTS CLUB BY PATIENT FOR THE PROCEDURE DESCRIBED IN THIS AUTHORIZATION AND CONSENT.

____

Client Signature Date

____

PRO Sports Club Representative Date

IF GUEST OR MEMBER IS A MINOR, SIGNATURE OF PARENT OR RESPONSIBLE ADULT IS REQUIRED BELOW:

1. PARENTAL RELEASE OF LIABILITY – In consideration of the minor child being permitted to utilize PRO Sports Club's facilities, I accept and agree to the full contents of this Release.

2. PARENTAL INDEMNIFICATION – I agree to release, indemnify, defend and hold PRO Sports Club harmless from all liabilities and future claims presented by my children or any other minor children and/or their parents, whose visit to PRO Sports Club is sponsored by me, for any injuries, losses or damages to themselves or any family member or registered domestic partner. This includes any claim of the minor and any claim arising from the negligence of PRO Sports Club.

3. PARENTAL REPRESENTATION OF AUTHORITY – I agree that I am authorized to sign this Release on behalf of the child by all of the parents and/or legal guardians of the child. I represent that all parents and/or legal guardians of the child know of and acquiesce to the signing of this Release and agree to waive and releaseany and all claims, suits or related causes of action against PRO Sports Club.

I HAVE FULLY INFORMED MYSELF OF THE CONTENTS OF THIS RELEASE BY READING IT BEFORE SIGNING IT. BY MY SIGNATURE BELOW I UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

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Parent/Guardian (if the guest or member is under the age of 18) Date

___

PRO Sports Club Representative Date