UNITY Medical Centre
2579 King St E. Hamilton, Ontario L8K 1Y4
Family & Urgent Care | Natural Medicine | Medical Aesthetics

LASER HAIR REMOVAL

INTAKE FORM

General Information

Name | Birthday

Address

State | Zip Code

Phone # | Email

Occupation

Emergency Contact Name | Phone #

Would you like to be added to our email list for specials and discounts? Yes ☐ No ☐

How did you hear about us?

Service(s) Being Performed Please check all that apply:

Face & Brows
- ☐ Brows
- ☐ Lip
- ☐ Chin
- ☐ Full Face
- ☐ Side Burns

Upper Body
- ☐ Full Arms
- ☐ Half Arms
- ☐ Underarms
- ☐ Back/Shoulder
- ☐ Abdomen
- ☐ Chest

Lower Body
- ☐ Full Legs
- ☐ Half Legs

Other
- ☐ Brazilian
- ☐ BIkini
- ☐ Full Body
- ☐ Other:

MEDICAL HISTORY Please check all that apply:

- ☐ Acne
- ☐ Bacterial Infection
- ☐ Diabetes
- ☐ Eczema
- ☐ Epilepsy/Seizure Disorder
- ☐ Fever Blisters
- ☐ High Blood Pressure
- ☐ Hyper/Hypo Pigmentation
- ☐ Low Blood Pressure
- ☐ Lupus
- ☐ Hyper/Hypo Thyroid
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Hysterectomy
- ☐ Irregular Periods
- ☐ Keloids
- ☐ Menopause
- ☐ Multiple Sclerosis/ALS
- ☐ Photosensitivity Disorder
- ☐ Polycystic Ovaries
- ☐ Pregnant
- ☐ Psoriasis
- ☐ Shingles
- ☐ Skin Pigmentation
- ☐ Rashes
- ☐ Warts

MEDICAL HISTORY

If you checked 'yes' on any of the boxes on the previous page under medical history, please explain:

Do you have ANY chronic medial history we should know about? **Yes** ☐ **No** ☐

If yes, please list:

Are you under a doctor's care now? **Yes** ☐ **No** ☐

If yes, please list:

Have you ever been treated with hormone medication? **Yes** ☐ **No** ☐

If yes, please list:

Have you had any surgeries in the past 6 months? **Yes** **No**

If yes, please list:

Have you ever been treated for cancer? Yes No

If yes, when and what types of therapies were used?

Are you currently taking any medications? Yes No

If yes, please list, including topical:

Do you have any allergies including but not limited to latex, lidocaine, or numbing agents?

If yes, please explain: Yes No

Do you have implants? Yes No

If yes, please list:

Have you had your hair professionally removed before? Yes No

If yes, please list areas, methods used, and date last removed:

SKIN CARE HISTORY

Please list any skin care products that you currently use:

Have you used any AHA products in the last 6 months?	Yes	No
Are you or have you used Retin-A, Renova, or Accutane in the last 6 months?	Yes	No
Are you using any other products and/or drugs that cause photosensitivity?	Yes	No
Are you exposed to the sun on a daily basis?	Yes	No
Do you currently have a sunburn?	Yes	No
Does your skin get blotchy, red, or irritated easily?	Yes	No
Do you plan on spending more time in the sun soon?	Yes	No
Have you recently used a tanning bed or spray tan?	Yes	No
Have you recently had a chemical or glycolic peel?	Yes	No
Is your skin sensitive to soaps, lotions, hydroquinone, or skin bleaching agents?	Yes	No
Have you had a tattoo or permanent makeup in the area(s) to be treated?	Yes	No

If yes, when?

If yes, did you have any adverse reactions? Yes No

If yes, please explain:

Do you have any abrasions, moles, or skin irritations in the areas being treated today? Yes No

If yes, please explain:

(Female clients) When is your next menstrual cycle due to begin?_____
(For your own comfort, we recommend avoiding hair removal from two days before to two days after your cycle.)

SKIN TYPE

To determine your skin type, please check the box which best describes your reaction to sun exposure:

- ☐ Skin Type I — Never tans, always burns (extremely fair skin, blonde/red hair)
- ☐ Skin Type II — Occasionally tans, usually burns (fair skin, sandy to brown hair, green/brown eyes)
- ☐ Skin Type III — Often tans, sometimes burn during first exposure to the sun (medium skin, brown hair)
- ☐ Skin Type IV — Always tans never burns (olive skin, brown/black hair)
- ☐ Skin Type V — Never burns (dark brown skin, black hair)
- ☐ Skin Type VI — Never burns (black skin, black hair)

By signing below, I agree to the following:

I have completed this form to the best of my ability and knowledge. I agree to inform the technician of any changes in the above information. I agree that I do not have any condition(s) that would make the requested treatment unsuitable. I will inform the technician of any discomfort I may experience at any time during my treatment to allow them to adjust accordingly. I agree to waive all liability toward my technician and the salon for any injury or damages incurred due to any misrepresentation of my health.

Name Printed	Signature	Date
Technician Name Printed	Signature	Date

Skin Typing

Please check the statements that most apply to you.

Score	0	1	2	3	4
What color are your eyes?	Light Blue, Gray Green	Blue, Gray	Green	Brown	Brown Black
What is the natural color of your hair?	Sandy Red	Blond	Chestnut Dark Blond	Dark Brown	Black
What is the color of your skin that is not exposed to the sun?	Reddish	Very Pale	Pale with Beige Tint	Light Brown	Dark Brown
How many freckles do you have on unexposed areas of your skin?	Many	Several	Few	Incidental	None

Reaction to Sun Exposure

Score	0	1	2	3	4
What happens when you stay in the sun too long?	Painful redness, blistering, peeling	Blistering followed by peeling	Burn sometimes followed by peeling	Rare burns	Never Burn
To what degree do you turn brown?	Hardly or not at all	Light color ran	Reasonable tan	Tan very easy	Turn dark brown quickly
Do you turn brown within several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
How does your face react to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem

Score	0	1	2	3	4
What happens when you stay in the sun too long?	Painful redness, blistering, peeling	Blistering followed by peeling	Burn sometimes followed by peeling	Rare burns	Never Burn
How long ago was the area to be treated exposed to the sun or artificial sunlamp/tanning cream)?	3+ months ago	2-3 months ago	1-2 months ago	Less than a month ago	Less than 2 weeks ago

TOTAL SCORE:

Skin Type Score	Fitzpatrick Skin Type
0-7	1
8-16	2
17-25	3
25-30	4
30-35	5
Over 35	6

Fitzpatrick Skin Type:

By signing below, I agree to the following:

I have completed this form to the best of my ability and knowledge. I agree to inform the technician of any changes in the above information. I agree that I do not have any condition(s) that would make the requested treatment unsuitable. I will inform the technician of any discomfort I may experience at any time during my treatment to allow them to adjust accordingly. I agree to waive all liability toward my technician and the salon for any injury or damages incurred due to any misrepresentation of my health.

Name Printed	Signature	Date
Technican Name	Signature	Date

UNITY Medical Centre
2579 King St E. Hamilton, Ontario L8K 1Y4
Family & Urgent Care | Natural Medicine | Medical Aesthetics

LASER HAIR REMOVAL

INTAKE FORM

_____ I understand that laser hair removal works by targeting the hair in the follicle, below the skin's surface, and that laser energy is transformed into heat which destroys the hair follicle leaving the surrounding skin unaffected.

_____ I understand that after each session, I will see substantial visible hair reduction and that each laser hair removal treatment will result in hair growth reduction. Additionally, hair will grow progressively slower, lighter, and finer with each treatment.

_____ I understand that it takes more than one treatment to affect all the follicles growing in an area and that a minimum of four to ten treatments will be necessary to achieve optimum results.

_____ I understand that no procedure can guarantee permanent hair removal, but most patients can expect a 60% to 70% reduction in hair growth.

_____ I understand that the number of sessions will vary for each individual and that the extent of long-term hair reduction will vary among clients because of the nature of hair and the many factors that influence the growth of hair.

_____ I understand that lighter-colored hair may require more treatments than darker-colored hair.

_____ I understand there are risks and complications that can occur from a laser treatment that can interrupt my daily life, work routine, or social life. These risks may include but are not limited to: crust formation, heat rash, bruising, burning, scarring, infection, hypopigmentation (lighter skin), hyperpigmentation (darker skin), damaged skin, abnormal healing, skin irregularities, skin depressions, wrinkling of the skin, unacceptable visible deformities, skin slough, loss of function, poor healing, visible patterns within the skin, wound disruption, permanent color changes in the skin, loss of sensation, distortion of the appearance of the eyelids, mouth, and other visible anatomic landmarks, and/or keloid formation.

_____ I understand that alternative forms of treatment include the use of razors, waxing, threading, and plucking.

_____ I understand that some swelling is normal following laser procedures and that the skin on or near the treatment site can appear either lighter or darker than the surrounding skin. Although uncommon, swelling and skin discoloration may persist for long periods and in rare situations may be permanent.

_____ I understand that in some cases, surgical revision or treatment may be required to treat the side effects of this treatment.

_____ I understand that I may need to wear protective eyeglasses during the course of the treatment to protect my eyes from the laser light, that I may inhale laser smoke during this treatment, and that this smoke may represent a possible biohazard.

_____ I understand that I may experience some mild pain during and/or after the laser treatment, and while chronic pain is very rare, it is possible.

_____ I understand that there is no guarantee or warranty expressed or implied on the results that may be obtained and that factors that could trigger new hair growth include hormonal imbalance/changes, pregnancy, medications, menopause, or exogenous steroids.

_____ I understand that I should avoid direct sun exposure or tanning beds for at least 4-6 weeks before and 2 weeks after my laser treatment. I have been informed to use a sunblock with an SPF of 30 or higher on the treated area during the course of my laser treatments.

ÜNITY Medical Centre
2579 King St E. Hamilton, Ontario L8K 1Y4
Family & Urgent Care | Natural Medicine | Medical Aesthetics

LASER HAIR REMOVAL

INTAKE FORM

_____ I understand that tanning during the course of my laser treatment is not recommended and can cause serious complications could result in serious complications including blistering, hypopigmentation (permanent whitening of the skin), or hyperpigmentation (permanent darkening of the skin). I understand that tanning includes sun exposure, the use of a tanning bed, and self-tanners. I understand it is very important to inform the provider if my skin is darker than when I had my last treatment so laser settings can be adjusted or treatment can be delayed if necessary for 2 weeks.

_____ I understand that pre and post-treatment care are very important and I will adhere to all the instructions given to me. Improper care to the treated area may increase the chances of complications, pain, or an unsatisfactory result.

_____ I consent to have photographs taken during the course of my treatments to be retained as part of my file. I understand all photographs are the property and are kept confidential.

_____ I authorize that I am not pregnant and that I will inform my provider if I become pregnant. I understand it is my responsibility to inform a provider of any medical or prescription changes.

_____ I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I understand that all payments are strictly non-refundable and that prices are subject to change without prior notice.

_____ I have read the aftercare home care instructions. I understand how important it is to follow all instructions given to me for aftercare. In the event that I may have additional questions or concerns regarding my treatment and suggested aftercare, I will consult the technician immediately.

_____ I have, to the best of my knowledge, given an accurate account of my medical history, including all known allergies or prescription drugs or products I am currently ingesting or using topically.

I have read and fully understand this agreement and all information detailed above. I have had ample opportunity to ask questions regarding laser hair reduction, side effects, and aftercare. Alternative methods of treatment and their risks and benefits have been explained to me. I understand that I have the right to refuse treatment. I agree I will assume the risk and full responsibility for any and all injuries, losses, side effects, or damages that might occur to me while I am undergoing this procedure. I release ÜNITY Medical Centre, it's staff, and providers from liability associated with this procedure. I certify that I am a competent adult of at least 18 years of age. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. This consent form is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors, and assigns.

Name Printed	Signature	Date
Esthetician Name	Signature	Date

UNITY Medical Centre
2579 King St E. Hamilton, Ontario L8K 1Y4
Family & Urgent Care | Natural Medicine | Medical Aesthetics

LASER HAIR REMOVAL

AFTERCARE INSTRUCTIONS

It is normal for the treated area to feel slightly sensitive (similar to mild sunburn) a few minutes after treatment to a day or more after. Please follow these instructions to optimize results and prevent skin irritation:

AFTERCARE INSTRUCTIONS

- Avoid hot water for 24–48 hours.
- No deodorant to the treated area for 48 hours.
- No exercise until the perifollicular edema (red bumps) resolves.
- No Jacuzzi, sauna, or steambaths until the skin is back to normal.
- Avoid irritants such as products containing glycolic acid or Retin-A in the area for 5 to 7 days.
- Avoid tanning and sun exposure for 4-6 weeks.
- You may use Aloe Vera and/or a cool compress or ice pack (over a thin towel) until any pain, redness, and/or swelling subsides.
- You may shave between treatments. However, do not wax or tweeze or depilate your hair when it starts growing in, as it needs to be in the follicle for the next treatment.
- Occasionally, crusts may form in some spots. Do not pick at them. Wash gently with fingertips and mild soap.
- Any crusted areas should be kept moist with a non-irritating moisturizer until healed. Apply an antibacterial ointment to the treated area like 1% hydrocortisone or Aloe Vera. Crusts generally heal within a week.

TREATMENT SCHEDULE

- For optimal results, multiple treatments are necessary.
- The number will vary depending on skin, hair type and hair color, and hormonal vs. non-hormonal areas.
- The treatment schedule ranges from 3 and 12 weeks, depending on the body area, treatment number, and prior hair removal methods.
- Results may be more noticeable after the second or third treatment.

SHEDDING

- You will notice hair resurfacing a few days to a few weeks after treatment.
- Gently exfoliating the area with a loofah or rough washcloth will help to lift the dead hair out of the follicles. You may start exfoliating a few days to a week after treatment, as long as the skin has returned to its original condition.

UNITY Medical Centre

LASER HAIR REMOVAL

PRECARE INSTRUCTIONS

PRE-TREATMENT INSTRUCTIONS

- Please shave any area of the body to be treated either the morning of, or the night before (with the exception of the face).
- No waxing, threading, or tweezing.
- Depilatory creams may be used 3 days prior to treatment.

PRECAUTIONS

- Itching: Do not scratch or pick an area that itches or shows signs of healing. Hydrocortisone works well for itching.
- Burning: Scarring or burning occurs in less than 1% of the treatment population. If the skin has blistered or has a superficial burn, call us and let us know.
- Sun Protection: It is important to protect the skin from sun exposure. Wear protective clothing and sunblock (SPF 30+ or SPF 50+) daily when in the sun for more than a few minutes. Be sure to reapply throughout the day. Unprotected sun exposure before, after, or between treatments could cause or worsen discoloration (hypo or hyper-pigmentation), especially during the first two weeks after each treatment.
- One should not undergo laser treatment if taking any sun-sensitizing medications or if tan (from the sun, tanning beds, or spray tans) in the area(s) to be treated.
- Accutane: You must wait at least six months after Accutane treatment ends before beginning laser hair removal.
- Alpha Hydroxy/Retin-A: Do not use Retin-A* or Alpha-Hydroxy for a minimum of 1 month before treatment.
- Pregnancy: Please let us know if you are pregnant or planning a pregnancy. Pregnant women should not undergo laser hair removal;
- Breastfeeding: You may breastfeed during treatment.
- Changes in Health or Lifestyle: Please let us know of any changes in your health, medication, or sun exposure between treatments; especially the use of sun-sensitizing medications or the possibility of pregnancy or actual pregnancy.