

Name: \_\_\_\_\_ Birth Date: \_\_\_ / \_\_\_ / \_\_\_ Age: \_\_\_\_\_  
Address: \_\_\_\_\_ Sex: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_  
E-mail: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_  
Allergies: \_\_\_\_\_  
For women: LMP: \_\_\_\_\_  
How did you hear about Spa Catalina? \_\_\_\_\_

Please put a check mark to the procedures about which you would like to receive more information:

- |  |   |
|--|---|
| <input type="checkbox"/> Acne Treatment                        | <input type="checkbox"/> Brown Spots                |
| <input type="checkbox"/> Botox to Flatten and Prevent Wrinkles | <input type="checkbox"/> Sun Damage                 |
| <input type="checkbox"/> Enhanced Skin Rejuvenation            | <input type="checkbox"/> Broken Capillaries         |
| <input type="checkbox"/> Wrinkle                               | <input type="checkbox"/> Spider Veins/Leg Veins     |
| <input type="checkbox"/> Skin toning or Pore Size Reduction    | <input type="checkbox"/> Hair Reduction             |
| <input type="checkbox"/> Facial Redness                        | <input type="checkbox"/> Shaving bumps/ingrown hair |
|  | <input type="checkbox"/> Dermal fillers             |

**Please put a check mark next to a past or current medical condition:**

**Medical History:**

- |   |   |
|---|---|
| <input type="checkbox"/> Lupus or other auto-immune deficiency              | <input type="checkbox"/> Herpes simplex or fever blisters (A)                             |
| <input type="checkbox"/> Rheumatoid Arthritis "Gold" Therapy (A)            | <input type="checkbox"/> Diabetes (A)   |
| <input type="checkbox"/> Currently Pregnant (A) or planning to get pregnant | <input type="checkbox"/> Light sensitive Epilepsy (A)                                     |
| <input type="checkbox"/> Bleeding abnormalities (A)                         | <input type="checkbox"/> Scars that turn white or brown (A)                               |
| <input type="checkbox"/> Treatment with Acutane in the last year (A)        | <input type="checkbox"/> Dark spots after pregnancy, skin injury (A)                      |
| <input type="checkbox"/> Treatment with Tetracycline in the last month (A)  | <input type="checkbox"/> HIV (A)  |
| <input type="checkbox"/> Keloid or very thick scarring (A)                  | <input type="checkbox"/> Hepatitis (A)  |
| <input type="checkbox"/> Psoriasis or Vitiligo (A)                          | <input type="checkbox"/> Waxing/Plucking? Electrolysis within last four weeks (HR)        |
| <input type="checkbox"/> Pulmonary embolism/blood clot (V)                  | <input type="checkbox"/> Hirsutism (HR)   |
| <input type="checkbox"/> Leg ulcer or Phlebitis (A)                         | <input type="checkbox"/> Transplant Anti-Rejection drugs (HR)                             |
| <input type="checkbox"/> Blood thinning medication (V)                      | <input type="checkbox"/> Chemical Peels, Dermabrasion, Laser Resurfacing or Face Lift (A) |
| <input type="checkbox"/> Coumadin/anti-clotting agent (A)                   | <input type="checkbox"/> Tattoos/permanent make-up  |
| <input type="checkbox"/> Cystic Acne (P)                                    | <input type="checkbox"/> Polycystic ovarian disease (PCOD)                                |
|   | <input type="checkbox"/> Implants (Location: _____)                                       |
|   | <input type="checkbox"/> Collagen injection (Location: _____)                             |

Please list any medications, allergies or herbal supplements that you are currently taking or may have:

\_\_\_\_\_  
Patient Signature

NAME \_\_\_\_\_ DATE \_\_\_\_\_

Please answer the following questions by circling the number which best describe you. Your clinican will total the score during the consultation.

**My ethnic origin is closest to:**  
**(check one)**

I. Very fair (Celtic and Scandinavian).....

II. Fair-skinned Caucasians with light hair and light eyes.....

III. Pale-skinned Caucasians with dark hair and dark eyes.....

IV. Olive-skinned (Mediterranean, some Asian, some Hispanic).....

V. Dark-skinned (Middle Eastern, Hispanic, Asians, some Africans).....

VI. Very dark-skinned (African).....

**My eye color is:**

Light blue.....0

Blue/green.....1

Green/gray/golden.....2

Hazel/light brown.....3

Brown.....4

**My natural hair color at age 18 was:**

Red.....0

Blonde .....1

Light brown.....2

Dark brown.....3

Black.....4

**The color of my skin that is not normally exposed to sun is:**

Pink to reddish .....0

Very pale.....1

Pale with a beige tint.....2

Light brown.....3

Medium to dark brown.....4

Dark brown-black.....6

**If I go out into the sun for an hour or so without sunscreen and have not been out in the for weeks, my skin will:**

Burn, blister and peel.....0

Burn, then when the burn resolves there is little or no color change.....1

Burn, but then turn to tan in a few days.....2

Get pink, but then turns to tan quickly .....3

Just tan.....4

Just gets darker.....5

My skin color is so dark I can't tell .....6

**When was the last time the area to be treated was exposed to natural sunlight, tanning booths or artificial tanning cream?**

Longer than one month ago .....0

Within the past month .....1

Within the past two weeks.....3

Within the past week.....4

**Total Score:**

| If your score is: | Your skin type is: | Notes |
|-------------------|--------------------|-------|
| 0 - 3             | I                  |       |
| 4 - 7             | II                 |       |
| 8 -11             | III                |       |
| 12 - 15           | IV                 |       |
| 16 -19            | V                  |       |
| 20 - 24           | VI                 |       |

## Treatment Consent and Release

I acknowledge that the practice of skin care and massage including microablation, microdermabrasion, electrolysis, facial toning, body treatment, laser treatment, IPL Photofacials, tattoo removal, vein treatments, brown spot removal, BOTOX, Collagen, Dermal Fillers, PCA PEELS, 70% Glycolic Peel, Sclerotherapy, Mesotherapy, Dermaplaning, and various other beauty or health procedures is not an exact science and no specific guaranties can or have been made concerning the expected result. I understand that some clients experience more change and improvement than others. In virtually all cases, multiple treatment are required in order to realize a difference.

I also realize that the following risks and hazards may occur in connection with any particular treatment including but not limited to: unsatisfactory results, poor healing, discomfort, redness, blistering, nerve damage, scarring, infection, change in the skin pigmentation, allergic reaction, muscle damage, herpetic skin eruptions, poor cosmetic outcome, recurrence of hair growth at treatment sites is also a possibility and increased hair growth, I understand that even though precautions may be taken in my treatment, not all risks can be known in advance.

Given the above, I understand that response to treatment varies on an individual basis and that specific results are not guaranteed. Therefore, in consideration for any treatment received, I agree to hold harmless and release from any liability on Spa Catalina as well as any officers, directors, contractors or employees of the above companies for any condition or result, known or unknown that may arise as a consequence of any treatment that I receive.

### GENERAL RISKS

Eye injury due to use of the laser system is a risk to the patient and to the clinician, however, the risks are dramatically reduced?(almost completely eliminated) with the use of proper eyewear.

Initial: \_\_\_\_\_ Date: \_\_\_\_\_

I acknowledge that if I am pregnant or become pregnant after I have signed this agreement for treatment I cannot pursue treatment until after pregnancy. My account is considered "frozen" and all money that has been paid are not refundable and non redeemable for cash but can be exchanged for services. All transactions are final.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### TEST SPOT WAIVER

**I would like to waive my test spot today. I have had laser hair removal treatment in the past. I understand that lasers vary and I hold Spa Catalina harmless to the unknown results that may arise as a consequence of my treatment today. I also agree to all terms and conditions listed above.**

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

### Attention Laser Clients

As a courtesy to our clients, we require a minimum of 24 hours for cancellation or rescheduling for laser treatments. If you are more than 10 minutes late, you may have to reschedule your appointment. This allows us to maintain consistency and better serve you and all other customers. Please, do not bring children under the age of 12 to your appointment. This policy is in place due to safety reasons that will protect your child or children.

All clients that do not give a 24 hour notice of cancelling or rescheduling will be given one “oops” which is a warning. After the next reoccurrence, you will then be assessed a \$25 FEE and thereafter. This will be added to your next treatment or billed directly to you, and must be paid before next treatment is rendered. **Note Only To: Groupon Customers, we may forfeit one of your 8 sessions and there after for each no show.**

**Note Only To : Groupon Customers– Laser Package consists of 8 sessions. Any additional sessions needed thereafter will be paid with individual pricing.**

### Laser Package Payments Options

A 50% deposit is due on the day of first treatment with the remaining balance to be paid in full on day of second treatment . If balance is not paid you may not schedule or receive 3rd treatment. Services are not covered by health insurance benefits. Other payment options are Cash, All Major Credit Cards and Checks. All transactions are final and non-refundable..

Consultations and test spots are required before sessions are started. The consultation fee is \$50 of which \$25 will be applied towards your total price . Test spots are included in the consultation fee. Prices are subject to change, but guaranteed if package is purchased at time of consult. Please call for current pricing if your quote has expired.

Individual Pricing- \$25 dollars is required with consultation and will be applied to 1st treatment.

Discounts are available for multiple areas treated at time of 1st treatment. (Please consult your technician for more information). The added treatments must be done at the same time to receive discount.

I have read and understand the above fee and schedule and terms;

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

Area (s) Quoted: \_\_\_\_\_ Fee Quoted: \_\_\_\_\_

Quote Expires: \_\_\_\_\_

8333 North Congress  
Kansas City, Missouri 64152  
Phone: (816)505-3-SPA FAX (816)505-3775

Permanent Hair Reduction Treatment Plan for \_\_\_\_\_

| Area to be treated | Estimated individual treatment time | Estimated treatments required | Estimated total treatment time for series | Frequency                  |
|--------------------|-------------------------------------|-------------------------------|---|----------------------------|
|                    |                                     |                               |   |                            |
|                    |                                     |                               |   |                            |
| Treatment summary  |                                     |                               |   | Treatment plan recommended |
| Totals             |                                     |                               |   |                            |

**Pre-treatment Instructions:**

- Inform us** if there has been any change in medical history.
- Inform us** if you have taken Accutane in the past year
- Inform us** if you have taken Tetracycline in the past month or are planning to begin taking it.
- Avoid** sun exposure or tanning beds 24 hours before or after you appointment.
- Do Not** apply self tanners to skin that is being treated 4 weeks prior.
- Do Not** use hair removal lotions or hair bleach for four weeks prior to treatment.
- Do Not** wax, tweeze or have electrolysis for four weeks prior to treatment. (only acceptable method is shaving)
- Wear** clothing that coincides with treatment being done, such as, tank tops, bikini, etc.
- Shave** the area to be treated within 1-2 days prior to the treatment. If treating heavy beard, shave the morning of your appointment. Do not shave for 3-4 days post treatment.
- Apply** Laser post crème suggested by your laser technician 1-2 days following treatment 2x a day.
- If using a mouth guard for Laser facial treatments, you must use a clear mouth guard.
- If your underarms are being treated, please **do not wear** deodorant on the morning of your appointment. You can bring it with you and put it on after your appointment.
- You can apply topical anesthetic as directed prior to coming in for your appointment.

**Post treatment requirements:**

- Apply** SPF30 sun block on all treated areas that may be exposed to the sun.
- Treatments area should be gently washed twice per day with tepid water and mild soap.
- Do Not** expose treated area to sun for prolonged periods for one week post treatment.
- Do Not** use Retin-A or glycolic for five days post treatment.
- Call us 48 hours prior to your next appointment if there is no hair re-growth in area to be treated.

**Post treatment expectations:**

- Hair loss will be most evident ten days to two weeks after treatment. After your treatment you may expect a mild sunburn sensation that typically lasts 2-3 hours and redness and swelling that may last one day. To treat these side effects, please follow these steps: Cold compresses may be applied to reduce redness and swelling.
- 8 or more treatments may be needed for maximum hair reduction. Laserscope studies show an 80% reduction of the hair after 8 treatments. Any remaining hair will be finer in caliber, therefore less visible.  Please call us at the first sign of persistent pain and blistering.

Permanent Hair Reduction Treatment Plan for \_\_\_\_\_

| Area to be treated | Estimated individual treatment time | Estimated treatments required | Estimated total treatment time for series | Frequency                  |
|--------------------|-------------------------------------|-------------------------------|---|----------------------------|
|                    |                                     |                               |   |                            |
|                    |                                     |                               |   |                            |
| Treatment summary  |                                     |                               |   | Treatment plan recommended |
| Totals             |                                     |                               |   |                            |

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Practice Name Here

**Laser/Intense Pulse Light Treatment Notes**

Patient Name: \_\_\_\_\_ Skin Type: \_\_\_\_\_

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| Date  |  |  |  |  |  |
| Wavelength /Filter used   |  |  |  |  |  |
| Change in Medical History   |  |  |  |  |  |
| Skin Type if changed  |  |  |  |  |  |
| Anti-Viral used   |  |  |  |  |  |
| Treatment #   |  |  |  |  |  |
| Treatment site  |  |  |  |  |  |
| Vein Size/color or Hair color and density or type of condition/lesion/ Severity of acne |  |  |  |  |  |
| Spot size   |  |  |  |  |  |
| Pulse Width   |  |  |  |  |  |
| Fluence   |  |  |  |  |  |
| Cooling (Solis)   |  |  |  |  |  |
| Number of passes  |  |  |  |  |  |
| Total Joules Delivered (Acne)   |  |  |  |  |  |
| Pulses per second   |  |  |  |  |  |
| Vein Effect   |  |  |  |  |  |
| Erythema  |  |  |  |  |  |
| Edema/Perifollicular edema  |  |  |  |  |  |
| Adverse Reactions   |  |  |  |  |  |
| Pain Scale (1-10)   |  |  |  |  |  |
| Anesthetic used   |  |  |  |  |  |
| Cold compress used  |  |  |  |  |  |
| Anti inflammatory or Ointment applied   |  |  |  |  |  |
| Post treatment instructions given   |  |  |  |  |  |
| Time Required   |  |  |  |  |  |
| Comments:   |  |  |  |  |  |
| MD/PA/RN  |  |  |  |  |  |

For **Erythema**, **Perifollicular edema** mark: + for mild, ++ for moderate and +++ for severe. For **Hair color**: BL for black, BR for brown, LB for light brown, BD for Blond, G for Gray, R for Red. For **Density**: C for coarse, M for medium and F for fine. Use Yes/No for **Medical History** and if post care done. For **Vein color**: R for Red, B for Blue, and P for Purple. Estimate vessel size 0.5 – 4 mm. For **Vein effect** mark: No effect, **Blanch**, **Gray** and rate + for mild, ++ for moderate and +++ for severe. For **Adverse Reactions** mark: Discoloration, Blistering, Singing and rate + for mild, ++ for moderate and +++ for severe. Use Yes/No for **Medical History**, and if post care done.