

# Ny New Look Aesthetics

Your Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Your Address: \_\_\_\_\_ Occupation: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

1. How do you wash your face? Soap <input type="checkbox"/> Cleanser <input type="checkbox"/>	14. Are you on a special diet? Yes <input type="checkbox"/> No <input type="checkbox"/>
2. If soap, what brand? _____	If yes, please specify _____
3. If cleanser, what brand name? _____	15. Do you consume water daily? Yes <input type="checkbox"/> No <input type="checkbox"/>
4. Do you use a moisturizer? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, how much? _____
5. Do you use Glycolic Acid on a regular basis? Yes <input type="checkbox"/> No <input type="checkbox"/>	16. Do you drink coffee, tea or soda daily? Yes <input type="checkbox"/> No <input type="checkbox"/>
6. Have you or are you currently using Retin A? Yes <input type="checkbox"/> No <input type="checkbox"/>	Coffee ozs. ____ Tea ozs. ____ Soda ozs. ____
If yes please specify _____	17. Do you exercise? Yes <input type="checkbox"/> No <input type="checkbox"/>
7. Are you/ have you taken accutane? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, how often? _____
If yes please specify _____	18. Have you ever had a facial? Yes <input type="checkbox"/> No <input type="checkbox"/>
8. Are you presently taking any medication? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, when was your last facial? _____
If yes, please specify _____	19. Do you give yourself a facial at home? Yes <input type="checkbox"/> No <input type="checkbox"/>
9. Do you ever have burning/itching on your skin? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, how often? _____
10. Are you allergic to anything? Yes <input type="checkbox"/> No <input type="checkbox"/>	20. Please list cosmetics and skincare you are currently using: _____ _____
If yes, please list _____	
11. Do you experience redness/irritation often? Yes <input type="checkbox"/> No <input type="checkbox"/>	Your signature: _____
12. Do you have heart trouble? Yes <input type="checkbox"/> No <input type="checkbox"/>	
13. Are you diabetic? Yes <input type="checkbox"/> No <input type="checkbox"/>	

**1. Skin Texture**

Thin  Thick  Medium

**2. Complexion color**

Pale  Pink  Olive  Sallow   
Suntanned  Other

**3. Pigmentation**

Even  Uneven  Birthmarks   
Heavy Freckling  Some Freckling

**4. Muscle Tone**

Good  Fair  Faller

**5. Facial Wrinkles**

Deep Wrinkles  Crow's Feet   
Fine Lines Through-out Face

**6. Broken Capillaries**

Nose Area  Cheek Area   
Chin Area  Nose   
Forehead

**7. Condition**

Pimples  Whiteheads   
Flakiness  Acne Scars  Blackheads

**8. Your Skin Type**

Oily  Combination  Dry   
Dehydrated  Sensitive   
Problem Acne  Couperose   
Mature  Sun Damaged   
Rosacea

Comments/ Recommendation	AM	PM	Recommended Facials
Cleanse			
Tone			
Hydrate & Protect			
Mask			
Special Night treatment			



## **PCA Skin Peel Consent Form**

Prior to receiving treatment, I have been candid in revealing any condition that may have bearing on this procedure, such as: pregnancy (if so, consult your physician prior to treatment), recent facial surgery, allergies, tendency to cold sores/fever blisters, or use of topical and/or oral prescription medications such as: tretinoin, Retin-A<sup>®</sup>, Accutane<sup>®</sup>, Differin<sup>®</sup>, Tazorac<sup>®</sup>, Avage<sup>®</sup>, EpiDuo<sup>™</sup>, or Ziana<sup>®</sup>.

I understand there may be some degree of discomfort such as stinging, pin-prickling sensation, heat or tightness.

I understand there are no guarantees as to the results of this treatment, due to many variables, such as: age, condition of skin, sun damage, smoking, climate, etc.

I understand I may or may not actually peel and that each case is individual. I understand that the amount of peeling does not correlate with degree of improvement.

I understand this treatment is a cosmetic treatment and that no medical claims are expressed or implied.

I understand that to achieve maximum results, I may need several treatments.

I understand that although complications are very rare, sometimes they may occur and that prompt treatment is necessary. In the event of any complications, I will immediately contact the physician/clinician who performed the treatment.

I agree to refrain from tanning in tanning beds or outdoors while I am undergoing treatment and during the 14 days, prior to and following the end of treatment (we recommend that this practice be discontinued altogether).

I understand that extended direct sun exposure is prohibited while I am undergoing treatment, and the daily use of sunscreen protection with a minimum of SPF 30 is mandatory.

I have not had any other chemical peel of any kind within 14 days of this treatment. I understand I cannot have another chemical peel within 14 days of this treatment, whether it is performed at this location or any other location.

I understand that I should follow my clinician's recommendations for post-procedure skin care to minimize side effects and maximize results.

I hereby agree to all of the above and agree to have this treatment performed on me. I further agree to follow all post-peel care instructions as I am directed.

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

Signature of Clinician: \_\_\_\_\_



## Testimonial, Photo & Video Release

Please initial any or all of the following that apply:

\_\_\_\_\_ I agree to allow my treatment photos, testimonials, and/or videos to be used for promotional purposes. I understand that my name and identifying information will **NOT** be used.

\_\_\_\_\_ I agree to allow **ONLY** my first name, last initial and occupation to be attached to my treatment photos, testimonials, and/or videos for promotional purposes.

\_\_\_\_\_ I **DO NOT** agree to allow the use of my treatment photos, testimonials, and/or videos for promotional purposes.

This agreement supersedes any previous agreement you have with New Look Aesthetics regarding testimonial, photo and/or video usage.

SIGNED: \_\_\_\_\_

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

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

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Written Testimonial About Your Experience at New Look Aesthetics