

INTAKE / Anamnesis FORM

Surname: First name:.....
 Address:.....
 Residence:..... Postal Code:.....
 Date of Birth: Sex: M / F
 Telephone number: E-mail:.....

Previous treatment methods;

Shaving / Waxing / Electric Epilation / Depilatory cream / Epilator / other IPL or Laser treatments

Do you suffer or have you suffered from one or more of the following diseases?

		Yes	No
1.	Kidney disease	<input type="radio"/>	<input type="radio"/>
2.	Allergies, such as photosensitivity or histamine reactions	<input type="radio"/>	<input type="radio"/>
3.	Blood or clotting diseases, such as thrombosis	<input type="radio"/>	<input type="radio"/>
4.	Endocrinological diseases, such as diabetes	<input type="radio"/>	<input type="radio"/>
5.	Hart disease, such as high blood pressure	<input type="radio"/>	<input type="radio"/>
6.	Skin and / or venereal diseases, such as herpes, psoriasis, eczema, keloid	<input type="radio"/>	<input type="radio"/>
7.	Cancer or skin tumors	<input type="radio"/>	<input type="radio"/>
8.	Immune diseases, such a reduced immune system	<input type="radio"/>	<input type="radio"/>
9.	Infectious diseases or inflammation	<input type="radio"/>	<input type="radio"/>
10.	Varicose veins or other vascular problems	<input type="radio"/>	<input type="radio"/>
11.	Disturbed hormone balance, e.g. a reduced estrogen level, increased androgen	<input type="radio"/>	<input type="radio"/>
12.	Nervous system diseases, such as epilepsy	<input type="radio"/>	<input type="radio"/>
13.	Do you use or have used medication, the contraceptive pill, including anti-biotics and excessive use of aspirin?	<input type="radio"/>	<input type="radio"/>
14.	Do you have a pacemaker, implants, prostheses or others?	<input type="radio"/>	<input type="radio"/>
15.	Do you use vitamin preparations?	<input type="radio"/>	<input type="radio"/>
16.	Do you use homeopathic remedies or herbal extracts, such as SintJanskruid, tea tree	<input type="radio"/>	<input type="radio"/>

		Yes	No
17.	Are you regularly exposed to sunlight, tanning beds or use self-tanning products?	<input type="radio"/>	<input type="radio"/>
18.	Do you have permanent make-up or a tattoo?	<input type="radio"/>	<input type="radio"/>
19.	Does your skin have irregularities in texture or pigment, such as pigmentation spots?	<input type="radio"/>	<input type="radio"/>
20.	Are you undergoing treatments that make your skin more sensitive, such as waxing?	<input type="radio"/>	<input type="radio"/>
21.	(For women) Are you pregnant?	<input type="radio"/>	<input type="radio"/>
22.	(For women) Is it your intention to become pregnant in the coming period?	<input type="radio"/>	<input type="radio"/>

Comments:

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How long has the hair been present and when did it start?

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I have answered all questions truthfully. It has been made clear to me that the incorrect or incomplete answering of the questions and the non-observance of the conditions may adversely affect the outcome of treatment.

Place **Client' s signature**.....

Date

Note: The signature of a parent or guardian is required for minors