BOSSY GLAM STUDIO

Consultation Form

Date:_____

Name:_____ Date of Birth:_____

Address:_____

Phone Number:_____ Email:_____

How did you hear about us?_____ Referred by:_____

Medical / Personal Information

[If you do not have a provider, please answer "n/a"]

Primary Care Physician: _____

Dermatologist: _____

Dental Provider or Practice: _____

Gynecologist/OBGYN: _____

Mental Health Provider: _____

Have you ever had body contouring or vacuum therapy treatments before? No ☐ Yes ☐

If so, when? _____

Are you pregnant, trying to get pregnant, nursing or is there a chance you might be? No ☐ Yes ☐ N/A ☐

Do you currently have a hernia? No ☐ Yes ☐

Do you have a pacemaker, or internal metal device (ie rods, plates, screws) ? No ☐ Yes ☐

Do you bruise easily? No ☐ Yes ☐

Are you taking any blood thinners ie asprin, warfarin, coumadin? No ☐ Yes ☐ Unsure ☐

Have you ever been treated with Accutane, Isotretinoin, or Retin-A? No ☐ Yes ☐ Unsure ☐

If so, when? _____

Do you exercise? No ☐ Yes ☐

If yes, list the frequency and intensity: _____

_____

Do you consume any tobacco or cannabis products? (select all that apply)

☐ Cigars ☐ Hookah ☐ Cannabis

☐ Cigarettes ☐ Vape ☐ Other: _____

If any, please list the type and frequency: _____

_____

Do you consume any alcoholic products? (select all that apply)

☐ Beer ☐ Liquor ☐ Wine ☐ Other: _____

If any, please list the type and frequency: _____

_____

Medical History

Allergies (select all that apply)

☐ Food ☐ Seasonal ☐ Drugs ☐ Other: _____

If any, please specify: _____

_____

Medications you are currently taking (select all that apply)

☐ Prescribed ☐ Herbs ☐ Supplements ☐ OTC

☐ Other: _____

If any, please list the type and the dosage: _____

_____

Have you ever had: ☐ Surgeries ☐ Hospitalization

Reason / Date(s): _____

_____

Family History (select all that apply)

☐ Allergies ☐ Neurologic Disorders ☐ Obesity

☐ Cancer ☐ Hypertension ☐ Heart Disorders

☐ Diabetes ☐ Genetic Disorders ☐ Other: _____

Please elaborate on the condition & Relationship: _____

_____

Treatment History

Are you currently being treated by a health care provider? (select all that apply)

☐ Primary Care ☐ Dental ☐ Dermatologist ☐ Mental Health

☐ OBGYN/Gynecologist ☐ Other: _____

If so, please specify: _____

_____

Have you had prior plastic surgery of the face or body? No ☐ Yes ☐

Have you had prior neurotoxin? No ☐ Yes ☐

Have you had prior permanent make-up services? No ☐ Yes ☐

Have you had prior dermal filler? No ☐ Yes ☐

If you answered any of the above 4 questions with "yes", please list details: _____

_____

Do you have any history of the following pre-existing conditions? [if yes, explain in the space provided]

Cancer or pre-cancerous lesions? No / Yes _____

Chronic Medical Conditions? [obesity, tobacco cessation, osteoporosis, ASCVD, diabetes, hypertension, hyperlipidemia] No / Yes

_____

Heart Disorder? [coronary heart disease, irregular heart beat, murmur, other] No / Yes

_____

Skin Disorder? [oral cold sores, keloids, hypertrophic scarring, skin diseases/lesions, other] No / Yes

_____

Autoimmune Diseases? [rheumatoid arthritis, ulcerative colitis, Crohn's disease, MS, other] No / Yes

_____

Communicable Diseases? [HIV/Aids, Covid-19, hepatitis, other] No / Yes

_____

Blood Clotting Disorders? [clots, phlebitis, hemophilia, thrombophilia, other] No / Yes

_____

Neurological Disorders? [stroke, seizures, bell's palsy, numbness of face, other] No / Yes

_____

I certify that the preceding medical, personal, and skin history statements are true and correct to best of my knowledge. I am aware that it is my responsibility to inform my technician of my past or current medical history in order for my technician to have the most current information on hand.

Signature: _____ Date: _____

Please answer the following questions so we can better service you:

What treatments are you interested in? [check all that apply]

- ☐ Prevention Therapies
- ☐ Correction Therapies
- ☐ Anti-Aging Therapies
- ☐ Regenerative Skin Treatments
- ☐ Facial Tightening/Contouring
- ☐ Body Contouring/Tightening
- ☐ Collagen Stimulation
- ☐ Active Acne Treatments
- ☐ Acne Scars and/or Dark Spot
- ☐ Skin Products
- ☐ Photo facial Pulse Light (IPL)
- ☐ Wellness Therapies
- ☐ Weight Loss Therapies
- ☐ 8-point Tox Facelift
- ☐ Non-surgical Butt Lift
- ☐ Other: _____

Do you have a Budget? [circle one]

$ $$ $$$ $$$$

Which most closely describes your:

Skin Type [select all that apply]

☐ Normal ☐ Oily ☐ Dry/dehydrated ☐ Acne-prone

☐ Mature ☐ Combination

Current skin care routine [select all that apply]

☐ Simple - Once a day ☐ Basic - am/pm ☐ Complex - 10 step

☐ Intermediary - Facials or face masks

☐ Advanced - Maintenance treatments (ie chemical peels, micro needling, photo facials)

List all skincare products that you use:

Cleanser: _____

Moisturizer: _____

Eye Cream: _____

Sunscreen: _____

Toner: _____

Antioxidant Serum: _____

Growth Peptides: _____

Retinol: _____

Reaction to the sun with no protection?

☐ Always burn, never tan ☐ Skin usually burns, tans w/difficulty ☐ Sometimes burn, tans gradually

☐ Rarely burn, tans easily ☐ Very rarely burns, tans very easily

☐ Never burns, tans very easy, deeply pigmented

Skin, hair, eye pigmentation?

☐ Light, pale white, likely blonde or red hair [blue eye color]

☐ White, peach, fair [blue, green, hazel eye color]

☐ White to light brown, olive [dark blue, hazel, brown eye color]

☐ Brown, dark brown [dark brown eye color]

☐ Olive, light to moderate brown [light brown, brown eye color]

☐ Very dark brown to black [dark brown eye color]

What are your main concerns? [check all that apply]

- ☐ Signs of aging/skin laxity
- ☐ Dark spots or pigmentation
- ☐ Cellulite or stretch marks
- ☐ Excess or unwanted fat/skin
- ☐ Under-eye bags or drooping eyelids
- ☐ Facial wrinkles, fine lines, creases
- ☐ Sun damage
- ☐ Volume loss
- ☐ Redness
- ☐ Uneven skin texture
- ☐ Active acne or rosacea
- ☐ Lack of muscle tone
- ☐ Acne scarring
- ☐ Jaw pain
- ☐ Freckles
- ☐ Collagen production
- ☐ Dehydrated or dry skin
- ☐ Other: _____

Please rank your top concerns [First, Second, Third]

_____

What are your treatment goals? _____

_____

_____

_____

What questions do you have? _____

_____

_____

Technician Notes: