

# BLADE

BEAUTY BAR

## CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate Permanent Makeup (PMU) treatment, you are required to complete the following form. All information is strictly confidential.

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

### **Client Information:**

Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Phone Number: \_\_\_\_\_

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

### **Emergency Contact Information:**

Full Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Medical History:**

Do you currently sunbathe or regularly use tanning salons? Yes  No

Do you smoke any product(s) containing nicotine? Yes  No

Are you currently under the care of a physician for management of an illness or condition? Yes  No

If yes, please specify: \_\_\_\_\_

Do you currently or have you ever had any of the following medical conditions?  
(Please check **all** that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> HIV/AIDS                       | <input type="checkbox"/> Keloid Scarring   |
| <input type="checkbox"/> Seborrheic Dermatitis          | <input type="checkbox"/> Blood clotting abnormalities  |
| <input type="checkbox"/> Hepatitis                      | <input type="checkbox"/> Cancer  |
| <input type="checkbox"/> Diabetes                       | <input type="checkbox"/> Cold Sores/Herpes   |
| <input type="checkbox"/> Skin Lesions / Infection       | <input type="checkbox"/> Psoriasis   |
| <input type="checkbox"/> Eczema                         | <input type="checkbox"/> Hormone imbalance   |
| <input type="checkbox"/> Breastfeeding / Nursing        | <input type="checkbox"/> Body Dysmorphic Disorder  |
| <input type="checkbox"/> Obsessive Compulsive Disorder  | <input type="checkbox"/> Organ Transplant(s)   |
| <input type="checkbox"/> Heart Issues/Arrhythmias       | <input type="checkbox"/> Immune Disorders  |
| <input type="checkbox"/> Cellulitis                     | <input type="checkbox"/> Keratosis   |
| <input type="checkbox"/> Active infection (of any kind) | <input type="checkbox"/> Hyperpigmentation<br>lingering red or brown spots after skin<br>injury or pimple etc. |

Do you have any other health problems or medical conditions not listed above?  
Please list:

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Have you ever had an allergic reaction to any food, drug or environmental source?  
(List any and all that you have had and describe the reaction you experienced)

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**CURRENT MEDICATION(S):**

Are you presently taking any oral prescription or non-prescription medications? Yes  No

If yes, please specify: \_\_\_\_\_

Are you presently taking blood thinners or immune suppression drugs? Yes  No

If yes, please specify: \_\_\_\_\_

Are you currently using any topical medications or creams? Yes  No

If yes, please specify: \_\_\_\_\_

Are you currently using any hair growth serums on the brows? Yes  No

Do you regularly use herbal supplements? Yes  No

If yes, please specify: \_\_\_\_\_

Are you pregnant or trying to become pregnant? Yes  No

Are you breastfeeding? Yes  No

Have you been on Accutane in the last year? Yes  No

**CLIENT ACKNOWLEDGEMENT**

I certify that the preceding personal history statements are true and correct. I am aware that it is my responsibility to inform my technician of my current medical or health conditions and to update this history as changes occur. A current medical history is essential for the technician to execute the safest treatment procedures.

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

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

I have read my client's personal history and find no contradictions to the desired service.

Technician Signature: \_\_\_\_\_

## Patch Test Consent/ Waiver

A patch test 48 hours prior to micro-pigmentation procedure is suggested to try to rule out the possibility of an adverse reaction. I understand that though suggested and carried out properly, a patch test without adverse reaction does not mean that there will be no adverse reaction after the actual micro-pigmentation procedure.

Initial

	I consent to a patch test
	I would like to waive my patch test and continue straight to my initial micro-pigmentation procedure. I accept all responsibility for any adverse reaction to any of the products used.

Client Signature: \_\_\_\_\_  
Technician Signature: \_\_\_\_\_  
Date: \_\_\_\_\_

### Patch Test Details:

Patch Test Location: \_\_\_\_\_  
Patch Test Date: \_\_\_\_\_  
Color(s) Used in Test: \_\_\_\_\_  
Brand Used in Test: \_\_\_\_\_  
Colors: \_\_\_\_\_  
Lot Number: \_\_\_\_\_  
Expiry Date: \_\_\_\_\_

## SEMI-PERMANENT MAKEUP CONSENT FORM AND RELEASE

### Client Information:

Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Phone Number: \_\_\_\_\_

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

### Initial

	I am over the age of 18
	I am not under the influence of drugs or alcohol
	I am not pregnant or nursing
	I desire to receive the indicated permanent cosmetic procedure

Procedure(s): \_\_\_\_\_

Technician: \_\_\_\_\_

Number of Visits Required: \_\_\_\_\_

Cost of Procedure(s): \_\_\_\_\_

The nature and method of the proposed semi-permanent makeup (micropigmentation) procedure has been explained to me as having the usual risks inherent in the procedure and the possibility of complications during and following its performance.

In initialing and signing this form I acknowledge that I am completely comfortable with proceeding with the semi-permanent makeup of my choice and in no way feel rushed or pressured into doing so.

I understand that:

Initial

	<p>There may be a certain amount of discomfort or pain associated with the procedure in spite of the fact that industry standard anesthetics are used properly according to the directions and that I am aware that each person's sensitivity to the procedure and to the anesthetic can vary greatly in spite of it being applied and used properly according to the instructions.</p>
	<p>There may be minor and temporary bleeding, bruising, redness or other discoloration and/or swelling in and around the area worked on.</p>
	<p>In rare cases pigment may "migrate" or spread outside of the desired area in spite of the procedure being done properly and pigments being applied correctly.</p>
	<p>I desire to receive the indicated permanent cosmetic procedure.</p>
	<p>I understand that applying makeup, dyes, tints or other substances following a semi-permanent makeup procedure can cause infections or other complications, I will not apply any makeup or other beauty products on or around the area treated for at least one week, and will not tint my brows or use hair growth serums on or around the area for 30 days.</p>
	<p>Fading or loss of pigment may occur as the area heals, especially in more oily or extremely flaky and dehydrated skin. Oily skin will absolutely have fading initially and lose the look of crisp lines in hair strokes, as well as fading faster in general and requiring more frequent touch-ups.</p>
	<p>I understand that the actual color of the pigment may be modified slightly after application and healing due to the tone and color of my skin, and may heal cooler or warmer than the desired tone; and that the color of my semi-permanent makeup will be darker and bolder immediately following the procedure but will lighten up by about 30% on average. I understand that this percentage is a generalization and that my body is unique. My individual results will depend on my skin, UV exposure, body chemistry, cosmetics and facial products and aftercare habits and cannot be predicted.</p> <p>*Sun Damaged Skin will always heal cool and may not be able to be warmed up regardless of color chosen.</p>

	<p>*Use of products with alpha hydroxy acids, glycolic acids or retinol etc. will fade pigment faster even if not used directly on the brow area.</p>
	<p>I fully understand this is a pigmentation process and therefore not an exact science, but an art and that achieving my desired results may take more than 2 appointments to achieve and that I will be responsible for the cost of any additional touch up appointments.</p>
	<p>I understand that symmetry is always the goal but that no one has a perfectly symmetrical face, and sometimes facial muscles are stronger on one side than the other which can affect the appearance of symmetry even though the pigments were applied properly when facial muscles were at rest. The symmetry of a procedure can also be affected by healing or the presence of hidden or visible scar tissue so minor touch ups may be needed to improve the symmetry of a micropigmentation procedure.</p>
	<p>I understand that no final outcome, degree of permanency, future removability or alterability is guaranteed and that I am paying for the desired procedure, products, and time involved.</p>
	<p>I have informed the practitioner of any and all of my known allergies and sensitivities and I acknowledge that it is not always reasonably possible to determine in advance whether I might have an allergic reaction to any of the pigments, dyes, topical preparations, or processes used in the procedure; and I agree to accept the risk that such reaction is possible. Due to the possibility of an allergic or adverse reaction to pigments or other products used in the service, a patch test at least 48 hours but preferably 1 week before the service is advisable however, I understand that a patch test however, does not ensure a client will not have an allergic reaction.</p>
	<p>I acknowledge that complications as a result of semi -permanent makeup procedures may occur, particularly in the event that the post procedural instructions are not followed, and accept full responsibility for such complications which can include, in rare cases, a secondary infection of the area worked on.</p>
	<p>I have previously had micropigmentation performed by someone else on the same area that I am asking to have worked on today</p> <p>____YES____NO</p> <p>IF YES, I understand that correcting or touching up micropigmentation that was performed by others involves additional risks because of the existence of permanent pigments already implanted of unknown composition, brand, color, age, shape and other factors over which my technician has no control. I understand that additional appointments</p>

	after the initial and follow up appointments may be required, and will be billed at my technician's standard rates. I understand that my technician cannot predict the results in advance and cannot guarantee and has not represented that the results will be as I desire.
	I acknowledge that obtaining the semi-permanent makeup is my choice alone, and I consent to the procedure and to its attendant risks, and to any actions or conduct of my technician that are reasonably necessary to perform the procedure.
	I understand that I will have the opportunity to approve the design and color of the semi-permanent makeup to be applied, and I accept responsibility for same.
	I consent to any relevant photographs being taken both before and after the procedure, to document the results of the procedure and that they can be used for marketing, informational and educational purposes as my technician sees fit. I waive any and all right to any form of compensation for the use of these photos.
	I have been given the full opportunity to ask any and all questions which I might have about obtaining semi-permanent cosmetic procedures from my technician, and all of my questions have been answered to my full and total satisfaction.
	I have received post procedure instructions and I will strictly adhere to such instructions. I understand that my failure to do so may jeopardize my chances for a successful procedure but that strict adherence does not guarantee a successful outcome.
	I understand that this procedure will result in a minor area of open skin that must heal, I will adhere to post care instructions and refrain from going to pools, or hot tubs for at least 10 days after my procedure to ensure that I am not exposed to possible infection.
	I understand that no pigments in the USA are currently FDA approved for use in micropigmentation and accept the risks of using them in this application.
	I agree to hold harmless _____ and any of his/her affiliates or employers for any and all undesirable outcomes of my semi-permanent makeup procedure in light of the fact that all such procedures are performed in compliance with government health and safety requirements and by a certified micropigmentation technician to the best of their ability and education, and release him/her from any and all liability for any injury, harm or loss of any kind whether it is physical, monetary, mental, emotional or otherwise as a result of the outcome of this procedure.



	Additional:

My initials on each of the preceding points indicate that I have read and fully understand the contents of each statement above. I acknowledge that this is a contract and that I have received no warranties or guarantees with respect to the benefits to be realized from, or consequences of, the aforementioned procedure(s).

I further acknowledge that at the time of signing this consent I am of sound mind and capable of making independent decisions for myself and am happy and confident in proceeding with this service.

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

Client Initials: \_\_\_\_\_

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

Technician Signature: \_\_\_\_\_

## Client Skin Assessment Form

### Client Information:

Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Phone Number: \_\_\_\_\_

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

### CLIENT SKIN TYPE:

Oily       Dry       Sensitive       Normal       Hyperpigmentation

Other: \_\_\_\_\_

Client Fitzpatrick Score: \_\_\_\_\_

Client Undertone:       Warm       Neutral to Warm       Neutral  
    Neutral to Cool       Cool

Client Skin Color/Tone: \_\_\_\_\_

Client Brow Color Preference when Healed:       More on the cooler side  
    More on the warmer side  
    More on the lighter side  
    More on the darker side

Client Brow Style Preference: \_\_\_\_\_

Additional: \_\_\_\_\_

## MICRO-PIGMENTATION PROCEDURE CHECKLIST - FIRST SESSION

### Client Information:

Full Name: \_\_\_\_\_

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

Technician: \_\_\_\_\_

### Patch Test Information:

Was a Patch Test Performed:  Yes  No – See Signed Waiver

Location of Patch Test: \_\_\_\_\_

Evidence of Adverse Reaction:  Yes  No

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

### Acknowledgements:

- A. I approve of the proposed shape and color of my brows and I am confident and comfortable with proceeding to the session:

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

- B. I have been shown the micro-pigmentation procedure needle. It was in an unopened, sterile package and has only been opened in front of me to use on my service.

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

Lot Number: \_\_\_\_\_

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

- C. I have witnessed the needle used on me being disposed of in a proper sharps container.

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

Technician Signature: \_\_\_\_\_

**MICRO-PIGMENTATION PROCEDURE CHECKLIST – TOUCH UP SESSION**

**Client Information:**

Full Name: \_\_\_\_\_

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

Technician: \_\_\_\_\_

**Results from Previous Session:**

Previous Session Color Healed To: \_\_\_\_\_

Client Preference for Touch Up: \_\_\_\_\_

**Patch Test Information:**

Was a Patch Test Performed:     Yes             No – See Signed Waiver

Location of Patch Test: \_\_\_\_\_

Evidence of Adverse Reaction:     Yes             No

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

**Acknowledgements:**

D. I approve of the proposed shape and color of my brows and I am confident and comfortable with proceeding to the session:

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

E. I have been shown the micro-pigmentation procedure needle. It was in an unopened, sterile package and has only been opened in front of me to use on my service.

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

Lot Number: \_\_\_\_\_

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

F. I have witnessed the needle used on me being disposed of in a proper sharps container.

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

Technician Signature: \_\_\_\_\_