# Violet Aesthetic Centre

## Oncology Esthetics

## Consent/Intake Form

Name________________________________________________________Date___________________

Address__________________________________________City______________Zip_______________

Email address_____________________________________Date of Birth_____/_____/_____________

Phone(_____)_____-_________Phone(_____)_____-_________

Who referred you to our office?__________________________________________________________

Emergency Contact name____________________________________Phone(_____)_____-_______

Doctor's Name_______________________________________________Phone(_____)_____-_______

What kind of skin issues are you experiencing?_____________________________________________

Are your experiencing any scalp issues?___________________________________________________

Are you experiencing any hair loss?_____Yes_____No   Do you wear a wig?_____Yes_____No

Are you experiencing any nail (finger or toe) issues?_____Yes_____No   If yes, explain__________

_________________________________________________________________________________________

**Medications:**

Chemotherapy?_____Yes_____No   Date started Chemo_______________________________

Name of Chemo Drug/s___________________________________________________________________

_________________________________________________________________________________________

Anti-coagulants_____Yes_____No   Steroids_____Yes_____No

Any other Medications or Supplements (Including Asprin, vitamins):___________________________

_________________________________________________________________________________________

List current skin care products that you use:________________________________________________

_________________________________________________________________________________________

**Please answer the following:**

Type of cancer_________________________________Date Diagnosed_________________________

*____Yes____ No  Surgery. If Yes, date/s____________________________________________________

*____Yes ____No  Incision. If Yes, site/location_____________________________________________

*____Yes____ No Port, PICC, Ommaya or Central Line. If Yes, location_________________________

*____Yes____ No Radiation Therapy. If Yes, date of last treatment_____________________________

*____Yes____ No Lymph Nodes removed. If yes, # of Lymph Nodes removed___________________

*____Yes____ No Lymphedema. If yes, location/side_______________________________________

*____Yes ____No Swelling or Inflammation. If yes, location:__________________________________

*____Yes____ No Radiation Burns. If yes, location:________________________________________

*____Yes____ No Pain or Burning. If yes, location:________________________________________

*____Yes____ No Poor wound healing. If yes, explain:_____________________________________

*____Yes____ No Hypersensitivity of Irritation. If yes, explain:_____________________________

*____Yes____ No Dryness. If yes, explain:______________________________________________

*____Yes____ No Rashes. If yes, explain:_______________________________________________

*____Yes____ No Skin Discoloration. If yes, explain:_______________________________________

*____Yes____ No Peripheral Neuropathy. If yes, explain:___________________________________

*____Yes____ No Hand/Foot Syndrome (PPE). If yes, explain:_______________________________

*____Yes____ No Fatigue. If yes, explain:_______________________________________________

*____Yes____ No Shortness of breath. If yes, eplain:_______________________________________

*____Yes____ No Chills or Loss of Balance. If yes, explain:__________________________________

*____Yes____ No Claustrophobia. If yes, explain:_________________________________________

Has cancer or cancer treatment affected and functions in your body?_______________________

_____________________________________________________________________________

**Allergies:**

Please list all known allergies (food, drugs,etc.)______________________________________

_____________________________________________________________________________

*I acknowledge that all the information provided by me is true and correct to the best of my knowledge and that I **must wait 48 hours after a Chemotherapy infusion** prior to having a SkinCare Therapy.

I also understand that due to my medical history, cancer therapy and medications, that some skin conditions may require more than one treatment to achieve the desired results.

I understand that in order to achieve certain results, I will need to discontinue the use of home care products containing ingredients that are too strong, aggressive or drying at this time. (These will be discussed with you by your Esthetician).

We appreciate your business. So that we can best serve all our clients, please be advised of these policies.

**Arrival Time:** Please aim to arrive 10 minutes before your scheduled appointment time. If you arrive after your scheduled appointment time, it may not be possible to extend the time available for your booked service; if your service is shortened due to your late arrival, you may still be charged the full cost of the service.

**Changing your appointment:** 24 hours' notice is required to reschedule or cancel a booked appointment, except in cases of contagious illness as described below.

If you, or another person in your household, has an infectious or contagious illness, please contact us as soon as possible to reschedule your appointment for a later date. There is no penalty or timeframe required in this case, for your safety and that of other clients.

*I agree to the policies described above.*

Signature_____________________________________________Date______/______/_______