NEVESKIN

×ARTEMIS.

Client Intake Form:

First Name: _____ Last Name: _____ DOB: _____

Treatment History

1. Have you ever tried any other aesthetic procedures in the past?

   □ Yes □ No

2. If “yes”, which ones?

   _____

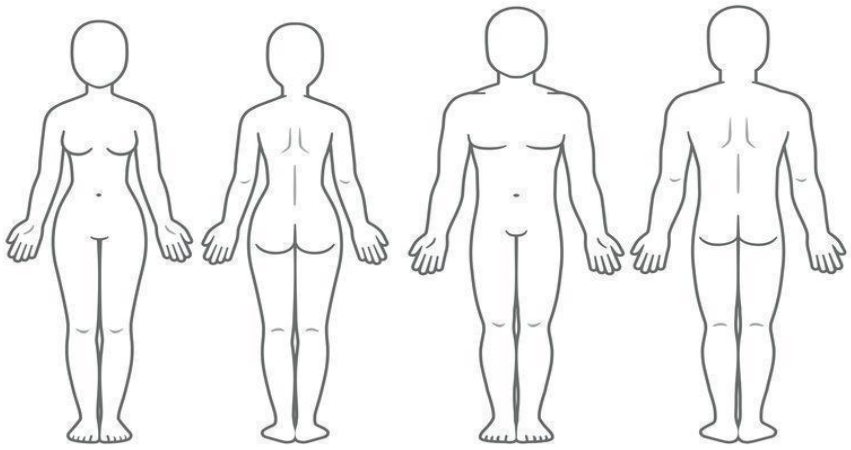
Lifestyle Information:

1. How many times per week do you exercise? _____

2. How much water do you drink per day? _____

3. How would you rate your diet?
   □ Extremely healthy □ Generally healthy □ Needs improvement

4. Please circle your areas of concern:



5. Have any other treatments/diets/exercise regimens helped these areas?

_____

6. What are your body/skin goals?

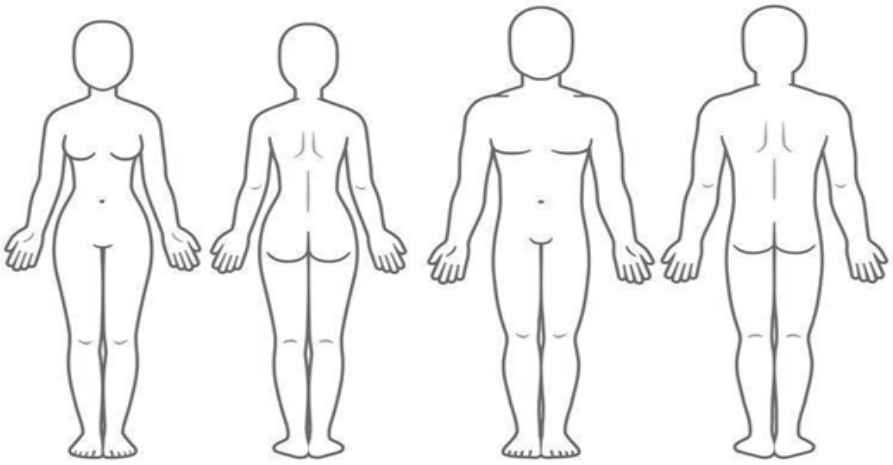
_____

7. Do you have any questions about Neveskin?

_____

Soothe:

1. Please circle the area in which you experience soreness, stiffness, or discomfort:



2. Was there a recent injury in the area? If so, please advise when and how:

3. Please provide more information on the area. For example, how long you have had soreness or discomfort, whether is it painful, and what you have previously tried:

4. Have you had this previously checked prior to your consultation with us, if so, please advise us on the feedback you were given:

5. Technician to fill out:

   Please advise of full consultation notes in regard to the soothe sessions:

Consent Agreement (the “Agreement”)

I, [client name], (hereinafter referred to as “Client”, “I”, “my”, “me”, “you”, and “you’re”) with full knowledge of the risks involved, hereby agree to the services as discussed with the Client or outlined in the Session Tracker attached hereto (hereinafter referred to as the “Service”) provided by [Company Name] (hereinafter referred to as “Company” and “we”) and do further acknowledge and give my express consent to the following:

I understand that results may vary depending on individual factors including but not limited to skin type, patient compliance with pre/post-session instructions, and individual response to treatment. I must be 18 years old to receive the Service. I am responsible for all aftercare recommended to me.

I hereby grant to Company all rights and title to all photographs and video or voice recordings of me obtained during the Service (hereinafter described as "MultiMedia") and waive my right to assert any claim thereupon and understand I will not receive any payment or compensation. The company may use any MultiMedia for any purpose, including but not limited to educational and promotional purposes. I understand that although MultiMedia will not contain my name or any other identifying information, I am aware that I might be identified.

All sales are final and refunds are not permitted. I accept full responsibility if I have not made my technician aware of any medical issues during the time of consultation and thereafter, if my health is affected during a course of treatments I will notify my technician immediately. The Services provided are no medical or health care services and employees of the Company are no health care practitioners and cannot diagnose or treat individual health problems.

It is not recommended for Neveskin to be used on or applied to clients who have certain medical conditions and/or contraindications as listed below, please answer the following questions :

Do you have cancer or a history of cancer?.....YES/NO
Do you suffer from serious kidney or liver disease?.....YES/NO
Do you have any lymphatic drainage disorders?.....YES/NO
Do you suffer from Type 1 Diabetes or have uncontrolled diabetes?.....YES/NO
Do you have a loss of sensation in your extremities?.....YES/NO
Are you pregnant, lactating, or undergoing IVF?.....YES/NO
Do you suffer from cold or heat sensitivity?.....YES/NO
Recent surgery? (last 6 months).....YES/NO
Do you have Eczema, Rashes, or dermatitis in or outside the treatment area?.....YES/NO
Have you had body or breast implants in the treatment area?.....YES/NO
Do you currently have any open or infected wounds in the treatment area?.....YES/NO
Do you have any mesh inserts in the treatment area?.....YES/NO
Are you suffering from any hormonal imbalances, menopause, or thyroid issues?.....YES/NO
Are you currently under the influence of any illicit or prescribed drugs or alcohol?.....YES/NO
Are you currently on any medications or topical antibiotics?.....YES/NO
Please List medications if the answer is yes:_____

By signing below, I [client name], certify that I have read and understand the Agreement. The answers provided herein are factual to the best of my knowledge. No warranty or guarantee, or other assurance, has been relied upon or made to me concerning the results of the Services nor its effects or side effects.

Client Name: ……..

Date:……

Client Signature: ……..

Technician:……

Session Tracker

SESSION 1 Date:	SESSION 2 Date:	SESSION 3 Date:	SESSION 4 Date:	SESSION 5 Date:

MEASUREMENTS

Before	After	Before	After	Before	After	Before	After	Before	After

IMAGE TAKEN

Session Type:	Date:	Changes to health/medication:	Client Signature:	Technician Initials: