Pre-Treatment Consent Form

Customer Name:

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Address:

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Email Address:

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Contact Number:

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Procedure(s):

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Confidential Medical History Questionnaire

Answer YES or NO to the following questions; if YES, give more details overleaf. If you do not understand any of the question please ask a member of staff.

Do you have a history of Cancer and undergone radiotherapy or chemotherapy in the past 5 years?	YES	NO
Are you taking or have taken steroids/cortisone in the past 12 months?	YES	NO
Are you allergic to any materials or products used?	YES	NO
Do you have a pacemaker or suffered heart conditions in the past?	YES	NO
Are you suffering from any form of liver disease?	YES	NO
Are you suffering from or had fibrosis, Hepatitis all forms?	YES	NO
Are you recovering from an operation within the last 6 weeks?	YES	NO
Are you diagnosed with any long-term medical conditions?	YES	NO
Are you suffering from osteoarthritis?	YES	NO
Do you have any metal plates or pins in your body?	YES	NO
Have you had acne treatment Ro-accutane within the past 6 months?	YES	NO
Are you Diabetic?	YES	NO
Do you have kidney disease?	YES	NO
Do you suffer from thyroid disorders?	YES	NO
Do you suffer from Epilepsy?	YES	NO
Are you on any blood thinning medication?	YES	NO

Treatment Restrictions

(This may limit or restrict the treatment)

Do you suffer from any skin conditions or diseases? (Eczema, Psoriasis etc)	YES	NO
Do you suffer from asthma, hay fever or any other allergies?	YES	NO
Do you suffer with blackouts, fainting or dizziness?	YES	NO
Do you have any silica implants?	YES	NO
Are you prone to bruising easily?	YES	NO

Please give details if any boxes are ticked YES

Additional Notes:

Terms & Conditions

Read this document carefully and if you agree that you have read the information leaflet, sign below.

Everything about the above named procedure to your satisfaction; have checked that the information on this form and the Client Registration form are correct and only if you approve and consent, sign below.

I authorise and consent to treatment for improving the appearance of cellulite/skin tightening using the procedure(s) listed on page 1.

I have been advised of the advantages and disadvantages associated with the above procedure and I agree that the therapist has adequately explained the proposed procedure and alternatives.

I understand that treatment experience and results with this procedure varies from client to client and as with all beauty therapy procedures, no guarantees can be made regarding the eventual outcome.

I understand that the primary benefits are for personal effect and not for medical or essential health reasons.

I am satisfied that I had enough “cooling off” opportunity to enable me to make a rational decision.

I accept that the cosmetic improvements are secondary to a healthy lifestyle and sensible diet and that exercise regimes must be maintained.

I have been given enough opportunities to ask questions and seek further information and have received satisfactory answers to all of them.

I accept, although rare, that adverse outcomes such as pain, bleeding, bruising, infection, numbness, scarring and lumps may occur.

I am aware that with relatively new procedures, there are no long-term studies on adverse effects and complications.

I authorise the taking of photographs.

I understand that use of such equipment is optional and entirely at my own risk.

I have completed a medical questionnaire and can confirm that all information is correct.

Client signature:

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Therapist signature:

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Date:

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