Client Medical Consultation / Treatment Record

Title (Mr/Mrs/Ms/Miss)**:**	**GP Name & Surgery:**	
Client Name:	**GP Contact No:**	
Address:	**Tel Home:**	
	Tel Work:	
	Tel Mobile:	
	E-mail Address:	
Postcode:	**Age:**	**Gender** (Male/Female)**:**

How did you hear about us?:

Are you currently suffering or have ever suffered from any of the following:			
	Yes	**No**	**Comment**
Epilepsy			
Urine infection			
Diabetes			
Cancer			
Medical oedema			
HRT (Hormone replacement therapy)			
Contraceptive			Pill / Coil / Other
Any Kidney problems or issues			
Auto immune disease			
Currently pregnant			
Gastric ulcers			
Any form of infection, fever or disease			
Cardio vascular conditions			(Thrombosis, phlebitis, hypotension, hypertension, heart conditions/disease)
Regular antibiotics/medications taken			If yes, please list….
Any condition already being treated by a practitioner:			
Use of recreational drugs or alcohol:			

List ALL medication / regular supplements that you are currently taking:

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Do you have any of the following:			
	Yes	**No**	**Comment**
Thyroid problems			
Any metal pins/plates/cosmetic implants			
Dermatitis or other skin issues			
Muscular/skeletal problems			Back aches / Pain / Stiff joints / Headaches
Digestive problems			Constipation / Bloating / Liver / Gall bladder / Stomach
Circulation problems			Heart / Blood pressure / Fluid retention / Varicose veins
Gynaecological problems			Irregular periods / PMT / Menopause
Nervous system			Migraine / Tension / Stress / Depression
Immune system			Prone to infection / Sore throats / Colds / Chest / Sinuses
HIV			

Lifestyle questions:			
	Yes	**No**	**Comment**
Last period dates:			
Job description:			
Do you eat regular meals?			How many per day?
Do you eat in a hurry?			
Do you exercise?			PLEASE TICK: Occasionally Irregularly Regularly
Please list types of exercise:			
Do you take vitamin supplements?			If yes, please list…
Do you suffer allergies?			If yes, please list…
How would you mark your current stress level? (1-10, where 1 is low, 10 is high):			
Do you smoke?			If yes, how many per day?…
Do you drink alcohol?			If yes, approximate units per week?..
Date of last visit to the Doctor:			

Please list any recent Operations / Fractures / Scars / Localised swelling:
(Within 3 months for fractures and 1 year for operations)

Client Treatment Consent Form

I duly authorise the practitioners of …….. to perform the iLipo procedure for the purpose of spot fat reduction / improving the appearance of cellulite. I am aware that clinical results may vary depending on individual factors, including medical history, client compliance with pre/post treatment instructions, and individual response to treatment. I have been made aware that my diet and the amount of exercise I do, will have a major effect on the results of my treatments. If I do not make an effort to address my dietary requirements and exercise, I am aware that the results achieved may not be retained.

I understand the treatment involves a course of treatments. The fee structure has been fully explained and I understand that I am required to pay for a course of treatments prior to any procedures taking place. I am fully aware that should I wish to cancel the course the outstanding treatment value is non refundable.

The course cost is £……(Client initials)……..

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and I understand that no guarantee can be given as to the final result obtained. I am fully aware that my condition is of a cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so.

I understand that it is my personal responsibility to inform the practitioner of the clinic named above of any changes to my medical history during the course of iLipo treatment sessions and I confirm that should this occur I shall advise the practitioner of any changes.

I consent to the taking of photographs and authorise their anonymous use for the purposes of medical audit, education and promotion. *Delete if preferred.*

I certify that I have been given the opportunity to ask questions, any questions have been answered to my satisfaction and that I have fully read and understood the contents of this consent form.

Client Name (Printed):……..

Client Signature:……

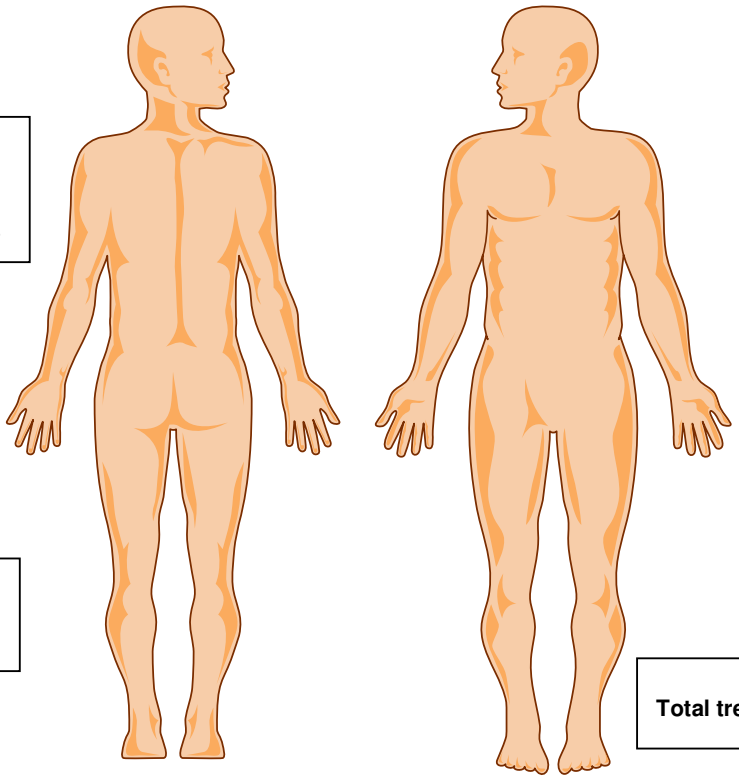
Date:……..

Practitioner Signature:……

Client Treatment Record

Client Name:
Date:
Area Treated:

Mark Lymphatic Probe placement with crosses



Mark pad placement with shaded area

Total treatment time:……..

Measurement Details:		
Point specifics	**Measurement before treatment**	**Measurement after treatment**
1.		
2.		
3.		
4.		

Notes:

Practitioner Signature:……