RF Tightening Medical Consent Form

Name:		
Age:		
Address:		
Email:		
Mobile:		
Gp Name and address:		
Are you currently suffering from any of the following?		
Active infections	**Yes**	**No**
Auto immune conditions	**Yes**	**No**
Cancer or in recess for less than 3 years	**Yes**	**No**
Chemical Face Peel	**Yes**	**No**
Cold or flu symptoms	**Yes**	**No**
Diabetes 1 or 2	**Yes**	**No**
Fluid retention in area being treated.	**Yes**	**No**
Fragile skin	**Yes**	**No**
High blood pressure	**Yes**	**No**
HIV	**Yes**	**No**
Hyperlipidaemia (raised serum levels of one or more of total cholesterol)	**Yes**	**No**
Immunosuppression (an act that reduces the activation or efficacy of the immune system	**Yes**	**No**
Joint Replacements	**Yes**	**No**
Keloid Scarring	**Yes**	**No**
Low/high blood pressure	**Yes**	**No**
Medications	**Yes**	**No**
Menstruation	**Yes**	**No**
Metallic Implants in the area being treated	**Yes**	**No**
Pacemaker	**Yes**	**No**
Photo sensitivity	**Yes**	**No**
Pregnancy, or breast feeding or chance of being pregnant	**Yes**	**No**
Recent Laser hair removal	**Yes**	**No**
Scarring/infection in the area being treated	**Yes**	**No**
Skin allergies or inflammation	**Yes**	**No**
Swollen lymph nodes	**Yes**	**No**
Tumours on area being treated	**Yes**	**No**

At Brows and Beauty by Nicky B we take your privacy seriously and will only use your personal information to administer your records and to provide the treatments and services you have requested from us. However, from time to time we would like to contact you with details of our latest promotions and treatments that we provide. If you would prefer to be excluded from any future marketing projects that we undertake please tick here _____

Best results will only be achieved if all aftercare advice is followed.

Have you had a Covid 19 Vaccine? Y/N (if yes please wait 6 weeks before booking in.

Please bring proof of age and ID

All medical and consent forms will be stored securely for 7 years.

I confirm the health history is accurate and complete. I understand that withholding any medical information may be detrimental to my health and safety during the procedure which the therapist agrees to undertake. If there are any changes in my medical history, it is my responsibility to advise the therapist before any further treatments are carried out. I agree that I understand the treatment I am having today.

Client Signature …….. Date……..

Therapist Name …….. Date……..

Practitioners Notes: Drs consent required? Y/N

Medications:

Health conditions:

Vaccine date: