

**Client Medical Consultation and Treatment Record**

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| **Client Title (Miss / Mrs / Mr / Ms / Other):****Client Name:** | **GP Name & Surgery:****GP Contact No:** |
| **Home Address:** | **Home Tel:****Mobile:****Email:** |
| **Post Code:** |  |

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| **Occupation:** |

***Are you CURRENLTLY suffering or have EVER suffered from any of the following – Please circle, ✓ (tick) and comment if applicable:***

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| --- | --- | --- | --- |
| **Condition** | **Yes** | **No** | **Comments / Info** |
| Epilepsy / Diabetes |  |  |  |
| Under 18 years |  |  |  |
| Electrical Implants |  |  | Pacemaker / Neurostimulator |
| Cancer or Lymphatic Disorders |  |  |  |
| Medical Oedema |  |  |  |
| Sensory Disorders |  |  | Thermethesia |
| Contraceptive |  |  | Pill / Coil / Other |
| Kidney or Liver Issues |  |  |  |
| Auto Immune Disease |  |  |  |
| Pregnant / Trying to conceive/ On Period |  |  |  |
| Gastric Ulcers / Crohn’s Disease / Colitis |  |  |  |
| Any form of Infection / Fever or disease? |  |  |  |
| Cardio Vascular Conditions |  |  | (Thrombosis / Phlebitis / HYPOtension / HYPERtension / Heart Conditions / Disease / Varicose Veins) |
| Any condition already being treated by a Practitioner? |  |  |  |

**Medication and Supplements**

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| **Medication / Supplement Name / Condition taken for** | **Length of time on Medication** | **Dosage** |
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| **Use of any recreational Drugs?** | **Regular Alcohol Intake?** |  **Do you Smoke / Vape?** |

**Do you have any of the following:**

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| --- | --- | --- | --- |
| **Condition** | **Yes** | **No** | **Comments / Info** |
| Thyroid Problems |  |  |  |
| Any metal pins / plates / Cosmetic Implants |  |  |  |
| Dermatitis or other skin issues |  |  | Keloid (raised) scarring |
| Muscular / Skeletal Problems |  |  | Back ache(s) / Pain / Stiff Joints / Headaches |
| Digestive Problems |  |  | Constipation / Bloating / Liver / Gallbladder / Stomach/ IBS |
| Circulation Problems |  |  | Heart / High BP / Low BP / Fluid Retention / Varicose Veins |
| Gynaecological Problems |  |  | Irregular Periods / PMT / Peri Menopause / Menopause |
| Nervous System |  |  | Migraine / Tension / Stress / Depression |
| Immune System |  |  | Prone to infection(s) / Sore throats / Colds / Cold Sores / Chest / Sinus  |
| HIV |  |  |  |

**Lifestyle Questions**

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| --- | --- | --- | --- |
| **Questions** | **Yes** | **No** | **Comments / Info** |
| Periods |  |  | Last period date: |
| Do you eat regular meals? |  |  |  |
| Do you eat in a hurry? |  |  |  |
| Do you exercise? |  |  |  |
| Do you take regular Vitamins / Minerals? |  |  |  |
| Any Allergies? |  |  |  |
| Current Stress Levels |  |  | 1-10 (1 being low, 10 being high) |
| Date of last visit to GP and reason why |  |  |  |

**Please list any Operations / Fractures / Major Scars / Localised Swelling you may have had:**

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| --- | --- |
| **Date** | **Details** |
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**Client Treatment Consent Section**

I duly authorise the practitioners of ***‘The Denwood Clinic’ / TL Aesthetics*** *(Circle)* to perform the ***LipoFirm Pro*** procedure for the purpose of spot / fat reduction / improving the appearance of cellulite / face and body skin tightening.

* I am aware that clinical results may vary depending on individual factors including medical history, client compliance with both pre and 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 treatment(s). 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 that to achieve the best results the best option is to have a course of treatments. The fee structure has been fully explained to me and I understand that I am required to pay for a course of treatments prior to any outstanding treatments being performed.
* I understand that if I cancel the course of treatments before completing the course – the remaining balance is non-refundable.
* I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications.
* I understand that no guarantee can be given as to the final result(s) 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 the *LipoFirm Pro* treatment sessions for face and body 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 / promotion. ***(Delete if preferred).***

I certify that I have been given the opportunity to ask questions and that any questions asked have been answered to my satisfaction. I have fully read and understood the contents of this consent form. I understand that these questions are given in regard to my safety and well-being. I have answered all questions to the best of my knowledge and am happy to proceed with LipoFirm Pro treatments for face and body.

**Additional Notes:**

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**Signed Consent Section**

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| **Client Name:** |  |
| **Client Signature:** |  |
| **Date:** |  |
|  |  |
| **Practitioner Name:** |  |
| **Practitioner Signature:** |  |
| **Date:** |  |

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[**www.thedenwoodclinic.co.uk**](http://www.thedenwoodclinic.co.uk)