TECHNICAL SHEET **CELLULITE**

DATE D M Y | Sheet #

CLIENT DATA

CUSTOMER NAME:	I.D. #
AGE:	SEX:
DATE OF BIRTH: D M Y	OCUPATION:
PHONE NUMBER:	E-MAIL:
IN CASE OF EMERGENCY CALL:	PHONE:

Reason for consultation:

MEDICAL HISTORY / BACKGROUND

MEDICAL CONDITIONS:

If the history referred to is a contraindication (see appendix: contraindications), the treatment may NOT be performed, however if the history has been overcome, the contraindication will be considered relative, and it is the treating physician who will authorize the aesthetic treatment.

HABITS AND LIFESTYLE

Do you drink water?	YES ☐	NO ☐	How many times a day?		
Do you smoke?	YES ☐	NO ☐	How many times a day?		
Alcohol consumption			HIGH ☐	MEDIUM ☐	LOW ☐
Energy drinks consumption			HIGH ☐	MEDIUM ☐	LOW ☐
Coffee consumption			HIGH ☐	MEDIUM ☐	LOW ☐
Soda consumption			HIGH ☐	MEDIUM ☐	LOW ☐
Fats			HIGH ☐	MEDIUM ☐	LOW ☐
Salt			HIGH ☐	MEDIUM ☐	LOW ☐
How much sleep do you get?					
Do you practice any sport?	YES ☐	NO ☐	Which one?		

Based on the above information, it is recommended that the client change his/her diet and lifestyle to ensure that the treatment responds optimally.

HAVE YOU HAD CELLULITE TREATMENTS?

WITH WHICH TECHNOLOGY?

ACHIEVED RESULTS:

AESTHETIC DIAGNOSIS

AESTHETIC ALTERATIONS (Please mark with an "X" to indicate the alteration)

CELLULITE	Hard ☐	Soft ☐	Edematous ☐	Area:

CELLULITE ATTENUATION TREATMENT IS ONLY AVAILABLE FOR CLIENTS WITH CELLULITE HARD AND SOFT

RECOMMENDATIONS FOR THE CLIENT: Eat food rich in proteins, vegetables, fruits and drink plenty of fluids, use natural products such as diuretics and detoxifiers, have a hypo caloric diet, wear control garments or containment stockings that are not too tight, exercise 1-2 times a day for 10-15 minutes with movement of the ankles and lower limbs to improve blood and lymphatic circulation, apply anti-edematous and firming cosmetics and at the end of the treatment have biweekly maintenance sessions.

AUTHORIZATION TO TAKE PHOTOGRAPHS

I consent to have photographs taken of me, to be used as support during my treatment. **YES** ☐ **NO** ☐

OBSERVATIONS FROM THE PHOTOGRAPHIC RECORD AT THE BEGINNING OF TREATMENT:

OBSERVATIONS OF THE PHOTOGRAPHIC RECORD AT THE END OF THE TREATMENT:

Client's Signature: _____

CELLULITE TREATMENT
AGREEMENT AND CONSENTS

I hereby authorize, and give my consent to: (esthetician name) _____ _____ to perform to me (client) _____ ID No. _____, a CELLULITE ATTENUATION TREATMENT. I acknowledge that this treatment has been thoroughly explained to me, its nature, purpose, advantages, disadvantages, discomforts and complications that may arise; and I have had the opportunity to ask questions and all my doubts have been resolved to my satisfaction and I have no further doubts.

I hereby consent to be photographed for the purposes of the application of this Body treatment and understand that these photographs will become the property of the establishment.

If I am allergic to any cosmetics, please state which _____ ; otherwise, I give permission to have the necessary Cosmetic products of this treatment applied to me,

_____

_____

The equipment or accessories to be used are: _____

_____

I acknowledge that I have been informed of their use, indications and contraindications, and I give my consent to their use in the treatment.

My signature confirms that I have fully and honestly answered all the questions I have been asked and I agree to be informed and agree with the treatment to be performed, knowing beforehand that the results of the treatment are composed of the application of the protocol, complemented with the self-care at home with healthy eating habits and moderate exercise.

My signature certifies that I have read, understood what is described here and that I agree with it.

_____ _____

CLIENT Signature PRACTITIONER Signature

ID. ID.

TREATMENT FOLLOW-UP

SESSIONS	DATE	PROCEDURE	SIGNATURE
1			
2			
3			
4			
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