CONFIDENTIAL CLIENT INFORMATION AND HEALTH HISTORY

Do NOT use this intake form for Medical Massage or Facials

Ultrasound Cavitation Consent Form

GENERAL INFORMATION

First Name: ____

Last Name: ____

Address: _________________________________ **Apt:** _________

City: __________________ **State:** _____________ **Zip:**__________

Current / Previous Occupation:_____________________________

Date of Birth ______/_______/________

Cell Phone: (________)_______________

☐ *Opt-in your cell phone to receive text alerts*

Gender ***(circle one)*****:** **Male** **OR** **Female**

Email: ______________________________

Emergency Contact Name: ______________________________

Relationship: ____

Phone: (________)_______________

How'd you hear about us? *(So, we can give credit)*

Name: ___________________________

MEDICAL BACKROUND:

(Check if you answer ***YES*** *to any of these)*

_____ Are you pregnant or nursing?
_____ Do you have any kind cancer?
_____ Acute inflammation?
_____ Are you epileptic?
_____ Do you have any cardiac or vascular problems?
_____ Do you have a wound that has not healed?
_____ Current or any history of internal bleeding?
_____ Do you have a pacemaker or other electronic device?
_____ Do you have ANY plastic or bone cement or large metal implant?
_____ Have you had any abdomen operations?
_____ Abnormally high or low blood pressure?
_____ Do you have high levels of Triglycerides (hereditary)?
_____ Are you allergic to zinc or nickel?
_____ Do you have hemophilia?
_____ Do you have melanoma?
_____ Do you have thrombosis and / or thrombophlebitis?
_____ Have you undergone a transplant?
_____ Do you have a Neurological disorder?
_____ Are you being treated with anticoagulants?
_____ Do you have any keloids?
_____ Do you have any kind of heart trouble?
_____ Do you have any current infection?
_____ Do you have any infectious disease or tuberculosis?
_____ Do you have advanced untreated diabetes?
_____ Do you have a communicable disease?
_____ Do you have any type of heart, kidney, liver disease?
_____ Any other medical condition?

ULTRASOUND CAVITATION TREATMENT AREA:

(Please check all that apply)

	Area		Area
	Abdomen		**Lower Back**
	Waist		**Upper Back**
	Neck		**Hips**
	Arms		**Buttocks**
	Inner/ Outer Thighs		**Calves**

If you checked any of the questions, please explain here:

____
____
____

Current medications that you are taking:

____
____

I,

____

have read through and answered honestly all of the above questions. All previous questions of mine have been answered and I understand the treatment in its entirety.

Client Signature:

____

Date:__________/__________/__________