Laser Lipo Inch Loss CONSENT FORM

Title: [Mr / Mrs / Ms / Miss]	**GP Name & Surgery Name:**		
Client Name:	**GP Contact Number:**		
Address:	**Tel. Home:**		
	Tel. Work:		
	Tel. Mobile:		
	Email Address: @		
Post Code:	**Age: [ ] Gender: [Male] [Female]**		

I duly authorize the technicians of _________________ to perform the Laser Lipo Inch Loss procedure for the purpose of spot fat reduction and skin tightening. I am aware that clinical results may vary depending on individual factors, including medical history, patient compliance with pre/post treatment instructions and individual response to treatment. I have been made aware that my diet and the amount of excercise I do, will have a major effect on the results of my treatments. **If I do not make an effort to address my diet and excercise, I am aware that the results will not be not be retained.**

I understand that treatment with the Laser Lipo machine involves a course of 8 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. The course cost is $ ___________ (client's initials)__________.

Due to the demand for treatments, all 8 appointments are scheduled in following the initial consultation. I have been made aware that all cancellations require a minimum of 24hrs notice.

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 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 clinician of any changes to my medical history during the course of Laser Lipo treatment sessions and I confirm that should this occur I shall advise the clinician of any changes.

I understand that after having the procedure it is possible that I may encounter some minor swelling of the area treated within the following 14 days. I have also been informed, and I understand, that it is possible that I could experience hyper/hypo-pigmentation on my skin. It has been explained to me that should this occur it depends entirely on an individual's reaction, dependent on the body's unique nature, but these marks should only be temporary.

I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit, education, marketing and promotion.

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form.

Client signature: ______________________________

Date: _________/________/___________

Witness: ______________________________

"STRAWBERRY"

Laser Lipo Inch Loss
MEDICAL QUESTIONNAIRE

Please list any / all medications that you are currently taking. Its the doctors descretion if he / she feels you are able to have a *Strawberry* Laser Lipo treatment course.

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Have you ever experienced any of the following specific conditions?
(Please circle where appropriate)

Epilepsy	NO/YES	
Diabetes	NO/YES	
Pacemakers	NO/YES	
Cancer	NO/YES	
Any Liver Problems	NO/YES	
Any Kidney Problems	NO/YES	
Auto immune disease	NO/YES	
Currently Pregnant or Breast feeding	NO/YES	
Have you ever experienced Hyper/Hypo-pigmentation?	NO/YES	
Any form of infection, fever or disease	NO/YES	
Photosensitivity	NO/YES	
Keloid Scarring	NO/YES	
Cardio Vascular Conditions	NO/YES	
Any condition currently treated by a Medical practitioner	NO/YES	
Any Tattoo's in the proposed treated area	NO/YES	Strawberry treatments may damage existing tattoos.
Thyroid problems	NO/YES	
Any metal pins or plates	NO/YES	
Muscular / skeletal problems	NO/YES	
Digestive problems	NO/YES	
Circulation problems	NO/YES	
Gynaecological problems	NO/YES	
Immune system	NO/YES	
LIFE STYLE QUESTIONS:		
Do you have regular periods	NO/YES	
Do you work at a computer?	NO/YES	
Do you eat regular meals?	NO/YES	
Do you eat in a hurry?	NO/YES	
Do you exercise?	NO/YES	
Do you suffer allergies?	NO/YES	
How would you mark your current stress Level?		
Enter date of last visit to doctor:	NO/YES	

Additional conditions not listed? (Please list below):

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Print name: ______________________________ Signature: ___________________________

Date: ____ / _____ / ______

"STRAWBERRY"

Laser Lipo Inch Loss
Female Body Chart

Client Name:

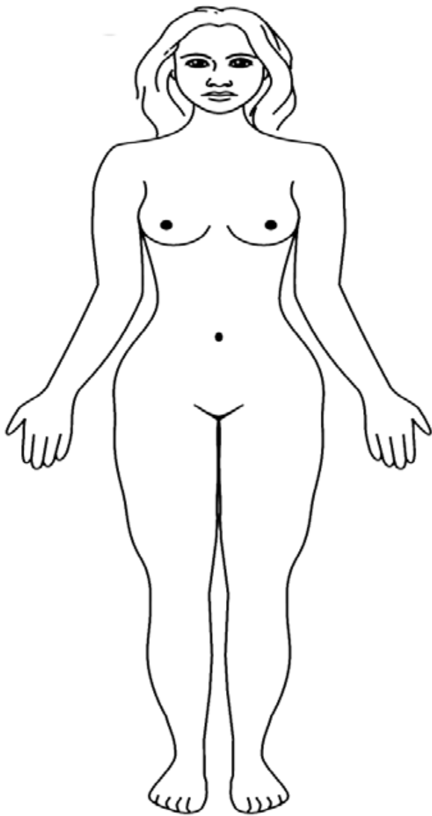
Date:

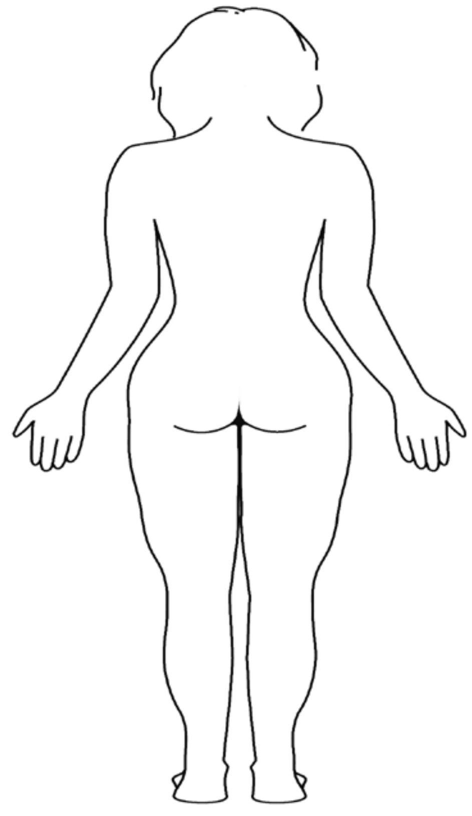
Area Treated:

Treatment No.: [1] [2] [3] [4] [5] [6] [7] [8] OTHER

LASER DIODE POSITIONS

Technician to mark where the probes are placed & duration of treatment





NOTES:

TECHNICIAN SIGNATURE:

"STRAWBERRY"

Laser Lipo Inch Loss
Male Body Chart

Client Name:

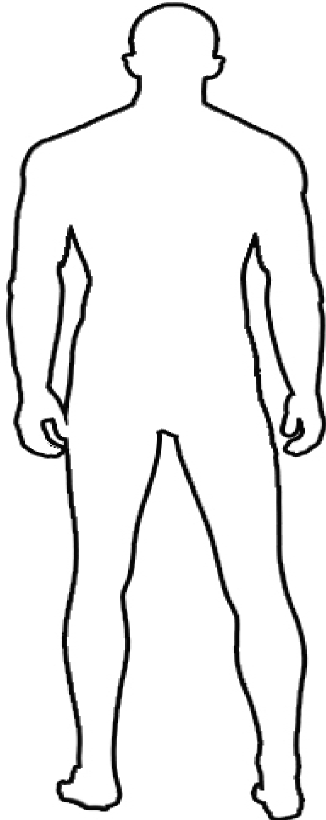
Date:

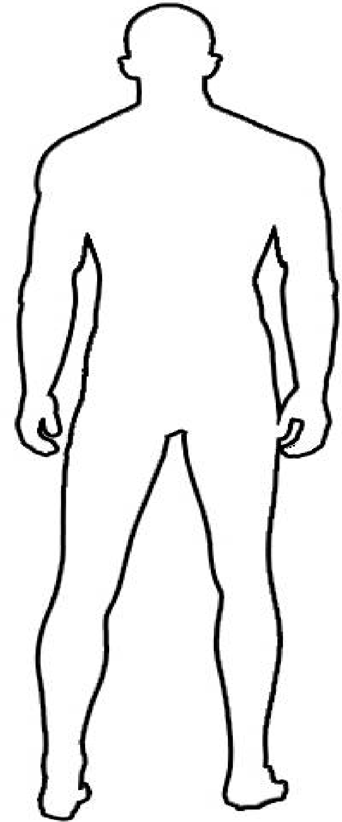
Area Treated:

Treatment No.: [1] [2] [3] [4] [5] [6] [7] [8] OTHER

LASER DIODE POSITIONS

Technician to mark where the probes are placed & duration of treatment





NOTES:

TECHNICIAN SIGNATURE:

LASER LIPO TREATMENT FORM	***STRAWBERRY*** **Laser Lipo**		
CLIENT NAME:			
TREATMENT NUMBER:			
BODY MEASUREMENTS & WEIGHT:			
	BEFORE	**AFTER**	**NOTES**
DATE:			
WEIGHT:			
TREATMENT NOTES:			