



## Client Medical Consultation / Treatment Record

<b>Title</b> (Mr/Mrs/Ms/Miss):	<b>GP Name &amp; Surgery:</b>	
<b>Client Name:</b>	<b>GP Contact No:</b>	
<b>Address:</b>	<b>Tel Home:</b>	
	<b>Tel Work:</b>	
	<b>Tel Mobile:</b>	
	<b>E-mail Address:</b>	
<b>Postcode:</b>	<b>Age:</b>	<b>Gender</b> (Male/Female):

**How did you hear about us?:**

<b>Are you currently suffering or have ever suffered from any of the following:</b>			
	<b>Yes</b>	<b>No</b>	<b>Comment</b>
Epilepsy			
Urine infection			
Diabetes			
Cancer			
Medical oedema			
HRT (Hormone replacement therapy)			
Contraceptive			Pill / Coil / Other
Any Kidney problems or issues			
Auto immune disease			
Currently pregnant or trying			
Gastric ulcers			
Any form of infection, fever or disease			
Cardio vascular conditions			(Thrombosis, phlebitis, hypotension, hypertension, heart conditions/disease)
Regular antibiotics/medications taken			If yes, please list....
Any condition already being treated by a practitioner:			
Use of recreational drugs or alcohol:			

**List ALL medication / regular supplements that you are currently taking:**



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Do you have any of the following:			
	Yes	No	Comment
Thyroid problems			
Any metal pins/plates/cosmetic implants			
Dermatitis or other skin issues			Keloid Scarring
Muscular/skeletal problems			Back aches / Pain / Stiff joints / Headaches
Digestive problems			Constipation / Bloating / Liver / Gall bladder / Stomach
Circulation problems			Heart / Blood pressure / Fluid retention / Varicose veins
Gynaecological problems			Irregular periods / PMT / Menopause
Nervous system			Migraine / Tension / Stress / Depression
Immune system			Prone to infection / Sore throats / Colds / Chest / Sinuses
HIV			

Lifestyle questions:			
	Yes	No	Comment
Last period dates:			
Job description:			
Do you eat regular meals?			How many per day?
Do you eat in a hurry?			
Do you exercise?			PLEASE TICK: Occasionally    Irregularly    Regularly
Please list types of exercise:			
Do you take vitamin supplements?			If yes, please list...
Do you suffer allergies?			If yes, please list...
How would you mark your current stress level? (1-10, where 1 is low, 10 is high):			
Do you smoke?			If yes, how many per day?...
Do you drink alcohol?			If yes, approximate units per week?..
Date of last visit to the Doctor:			

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



## Client Treatment Consent Form

I duly authorise the practitioners of ..... to perform the Lipofirm Plus 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 pre/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 treatments. 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 the treatment involves a course of 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. I am fully aware that should I wish to cancel the course the outstanding treatment value is non refundable.

The course cost is £.....(Client initials).....

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and 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 practitioner of the clinic named above of any changes to my medical history during the course of Lipofirm Plus treatment sessions for face or 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 and promotion. Delete if preferred.*

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

Client Name (Printed):.....

Client Signature:.....

Date:.....

Practitioner Signature:.....

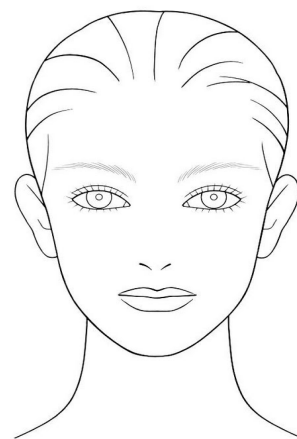
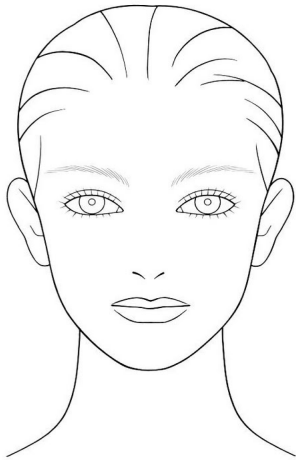


## Facial Consultation

### Specific Facial Questions

- |  |                                |
|--|--------------------------------|
| 1. Have you ever taken Accutane or Roaccutane? Yes or No             | if Yes please state:.....      |
| 2. Have you recently taken antibiotics? Yes or No                    | if Yes please state:.....      |
| 3. DO you take the contraceptive pill? Yes or No                     | if Yes please state:.....      |
| 4. Have you ever had any allergies to skin products? Yes or No       | if Yes please state:.....      |
| 5. Have you ever had any reactions to facials? Yes or No             | if Yes please state when:..... |
| 6. Please provide details of your skin regime including brands used? |                                |
|  |                                |
| 7. Do you suffer with heat rashes, rosacea or hives? Yes or No       | if Yes please state:.....      |

Facial area receiving treatment:



Key Facial Notes:

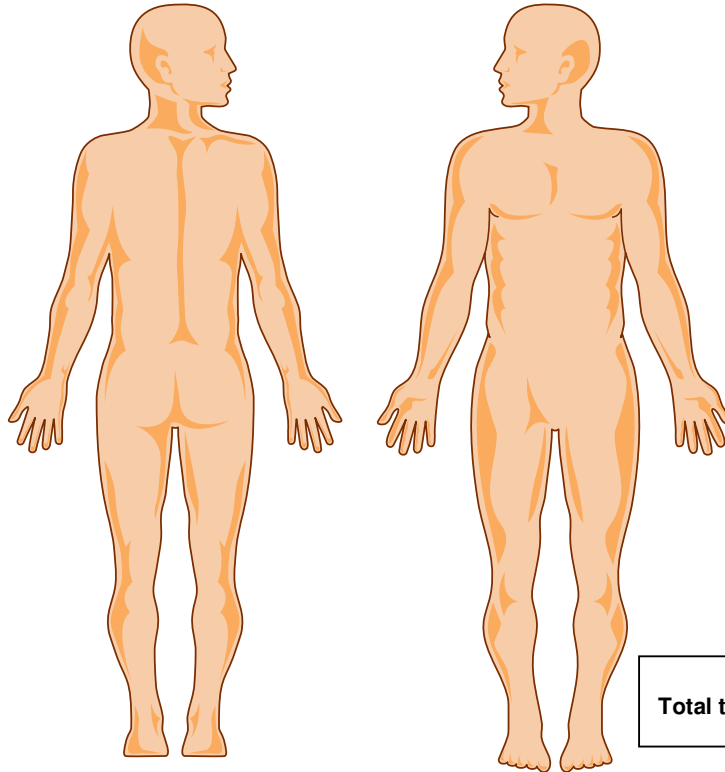


## Client Treatment Record

Client Name:

Date:

Area Treated:



Total treatment time:.....

### Measurement Details:

Point specifics	Measurement before treatment	Measurement after treatment
1.		
2.		
3.		
4.		

Notes:

Practitioner Signature:.....

Name

Age

Area

Height

Weight

Measurement Parameters  
 1.  
 2.  
 3.

Session Number	1		2		3		4		5		6		7		8	
	Before	After	Before	After	Before	After	Before	After	Before	After	Before	After	Before	After	Before	After
Area 1																
Area 2																
Area 3																
Sub Total																
Loss																
Cummlative Loss																
Time of Day																

Notes

Patient Basel Metabolic Requirement Calculation

BMR Formulas  
 Women BMR =655 +(9.6xweight in kilos) + (1.8 height in cm)-(4.7 x age in years)  
 Men BMR = 66 +(13.7xweight in kilos)+(5xheight in CM)-6.8xage in years)

if you are sedentary (little or no exercise) : Calorie-Calculatation = BMR x 1.2  
 if you are lightly active (light excercise/sports 1-3 days/week) : Calorie-Calulation = BMR x 1.375  
 if you are moderatley active (moderate excercise/sports 3-5 days/week) : Calories-Calculatation = BMR x 1.55  
 if you are very active (hard excercise/sports 6-7 days a week) : Calorie-Calculatation = BMR x 1.725  
 if you are extra active (very hard excercise/sports & physical job or 2x training) : Calorie-Calculatation = BMR x 1.9