ULTRASOUND CAVITATION CONSENT FORM

Name: _____ DOB: _____Date: _____

Address: _____ State _____ Zip_____

Email: _____ Cell: _____

ULTRASOUND CAVITATION TREATMENT AREA: (Please check all that apply)

_____Abdomen
_____ Waist
_____ Neck
_____ Arms
_____ Inner/ Outer Thighs
_____ Lower Back
_____ Upper Back
_____ Hips
_____ Buttocks
_____ Calves

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 any large metal implant?
_____ Have you had any abdomen operations?
_____ Abnormaly 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?

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

_____
_____

Current medications that you are taking: _____
_____
Are you taking any recreation drugs? _____

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: _____

Licensed Master Esthetician: _____Date: _____