**HI-EMT Consultation Form**

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| **Client Name:** | **Address:** |
| **Date of Birth:** | **Post Code:** |
| **Gender:** Male Female | **Telephone No:** |
| **Occupation:** | **E-Mail:** |
| **Practitioner Name:** | **Date:** |
| **Health and Lifestyle** |
| **Do you have any of the following?** |
| Liver/Kidney Disease\* | YES | NO | Hyper or Hypotension | YES | NO |
| Heart Conditions inc. Pacemaker\* | YES | NO | Scarring history, fibrosis or seborrhoea | YES | NO |
| Silicosis or any other Lung Conditions\* | YES | NO | Haemophilia or other clotting disorders | YES | NO |
| Cancer\* | YES | NO | Epilepsy\* | YES | NO |
| Undergoing Radiotherapy/Chemotherapy\* | YES | NO | Diabetes | YES | NO |
| Cardiovascular Disease\* | YES | NO | Hormonal Imbalances | YES | NO |
| Cerebral Disease\* | YES | NO | Other immune disorders not listed | YES | NO |
| Immune System Disease (i.e. AIDS or HIV)\* | YES | NO | Received or donated organ transplants | YES | NO |
| Other immune disorders | YES | NO | Pregnancy | YES | NO |
| Hernia or weak stomach muscle walls | YES | NO | Recently given birth | YES | NO |
| Physiological Hypotonic (Muscle Wastage) | YES | NO | Currently Menstruating | YES | NO |
| Blood Clotting Disorders | YES | NO | Broken Bones | YES | NO |
| Recent invasive surgery (in the last 12 months) | YES | NO | Undiagnosed swelling or inflammation | YES | NO |
| Metal Plates, Pins or Joint Implants | YES | NO | Bruising, cuts or abrasions (treatment area) | YES | NO |
| Silicone implants | YES | NO | Fever | YES | NO |
| Alcohol or drug misuse/Intoxication | YES | NO | Varicose Veins | YES  | NO |
| Any other conditions not listed? Please specify: |
| If you have answered yes to any of the above, please give full details: |
| Are you currently taking any medication? | YES | NO |
| If yes, please list all medications |
| How is your sleep pattern? Good Average Poor | No. of Hours Sleep per night: |  |
| How is your diet? Good Average Poor | How much water do you drink per day? |  |
| Do you drink alcohol? | YES | NO | If yes, how many units per week? |  |
| Do you smoke? | YES | NO | If yes, how many cigarettes per day? |  |
| Do you exercise? | YES | NO | How often do you exercise per week? |  |
| Have you ever had body contouring, fat removal or similar treatments before? If yes, please give details below including the type of treatment and the area. | YES | NO |
| Are you fully committed to making the relevant changes to get the best possible results from your treatment? | YES | NO |

**Informed Client Consent to HI-EMT Body Sculpting Treatments**

I, ……………………………………………….. consent to, and authorise, the Qualified Practitioners of ……………………………………………….(clinic name) to carry out HI-EMT (High Intensity Electro-Muscular Therapy) treatments as discussed and agreed.

The areas to be treated are: ………………………………………………………………………………………..

• The treatment has been fully explained to me. I understand that this treatment will take several sessions and a course of treatments is recommended for best results.

• I have been advised that results vary from person to person and that results will also depend on how well I follow my aftercare advice.

 • I agree to follow all the aftercare advice as provided by my therapist (namely drinking lots of water, regular body brushing, following a healthy diet and partaking in regular exercise). Whilst I understand that the results from the treatments vary considerably, I accept that all treatments are to be carried out in good faith with the best possible achievable outcome observed.

• I understand that there is a risk of some side effects including but not limited to, reddening and muscular tenderness. I accept these risks are possible and do not hold the therapist or company responsible for any adverse reactions that may occur from treatment.

• I have asked all relevant questions appertaining to this treatment and am satisfied with the explanation and information given to me regarding the possible side effects and outcome of HI-EMT.

• I have been given full pre and post treatment advice and understand and agree to follow these guidelines at all times during the treatment programme.

• In the unlikely event of an adverse reaction, I will advise the salon/clinic within 24 hours and, in the cases of ore serious side effects, will contact my GP to obtain medical advice.

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• I confirm that I am over the age of 18 years

• I confirm that I have read and agree to all the guidelines and recommendations of this Informed Consent Form.

Client Signature: ………………………………………………………………………… Date: ………………

Practitioner Signature: ………………………………………………………………. Date: ………………