Consultation Form for Non-Surgical Breast & Buttock Enhancement

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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 (please tick)?** | | | |
| Heart Conditions inc. Pacemaker  Pregnant or Breastfeeding  Epilepsy  Diabetes  Light sensitive migraines/Headaches  Metal pins or plates in the treatment area  Recent Stroke  Breast/Buttock Implants  Breast Cancer (past or present)  Thyroid conditions  Open wound in the treatment area  Taking Accutane (within last 12 months)  Using topical or systematic steroids (NSAID’S) | | | |
| 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 | | | |

# I understand that treatment uses a combination of vacuum suction, vibrational massage, microcurrent and LED light to provide volume to the breasts/buttocks. 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 understand that there is a risk of some side effects including but not limited to, reddening, bruising, slight friction blistering and 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, ……………………………………………….. now consent to, and authorise, the Qualified Practitioners of ……………………………………………….(clinic name) to carry out Non-surgical Breast/Buttock Enhancement treatments as discussed and agreed.

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

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