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| C O L L A G E N L I F TTM  P R O F E S S I O N A L |

# CONSULTATION FORM

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Therapist/Practitioner’s Name: Ceri Parker** | | | | | **Date:** |
| **Client Details (delete Yes or No or as applicable)** | | | | |  |
| Client Name: |  |  | Address: | | |
| Date of Birth: |  |  |
| Gender: | Male | Female | Postcode: | | |
| Occupation: |  |  | Tel. No: | | |
| Over 18? | Yes | No | I consent to my data being stored in the Collagen Lift ™ machine. If not, an anonymous reference number will be allocated. Ref: .............................. | | |
| Email: |  |  |  | | |

## Health and Lifestyle

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Major Contraindications**  **- Do not proceed (delete Yes or No as applicable)** | | |  | **Minor Contraindications**  **- Proceed avoiding affected areas**  **(delete Yes or No as applicable)** | | |
| Kidney/Liver disease | Yes | No | Psoriasis or eczema | Yes | No |
| Heart conditions (Pacemaker) | Yes | No | Areas of sensory impairment | Yes | No |
| Auto-immune diseases | Yes | No | Areas of very dry or fragile skin | Yes | No |
| Diabetes | Yes | No | Herpes (Shingles/cold sores) | Yes | No |
| Immuno-suppressed individuals | Yes | No | Bruises, abrasions or wounds | Yes | No |
| Chronic respiratory failure | Yes | No | Active acne | Yes | No |
| Cerebral palsy | Yes | No | Moles or skin tags | Yes | No |
| Inflammation or infection | Yes | No | Metal pins/Plates/Implants | Yes | No |
| Abnormal swelling/Oedema | Yes | No | Dental implants, braces, caps, metal fillings - For facials, please circle all that apply | Yes | No |
| History of keloid scarring or  abnormal wound healing | Yes | No |
| Inability to communicate | Yes | No |  |  |  |
| Connected to vital signs monitoring | Yes | No | Any areas of surgical, invasive or ablative procedures in the treatment area before  complete healing | Yes | No |
| Benign or malignant tumours | Yes | No |
| Arteriosclerosis obliterans | Yes | No |
| **- Follow the advice given to proceed** | | | Any other conditions not listed? Yes No  If yes please list:  If you have answered yes to any contraindications, please give full details: | | |
| Varicose Veins | Yes | No |
| *If on the body; just avoid body treatments*  Pregnancy  *Must wait until after 6 week check up* | Yes | No |
| Cancer (Radiation/Chemotherapy)  Especially skin cancer, pre-malignant moles in the treatment area  *Must wait until in remission for 6 months* | | |

## Medication (delete Yes or No as applicable)

To ensure that you have no adverse reaction to Collagen Lift ™ treatments it is important for us to know if you are taking any medication. We may need to ask you to obtain Doctor’s consent before we can proceed with treatment.

|  |  |  |  |
| --- | --- | --- | --- |
| Are you taking any medication/recreational drugs? | Yes | No | *It is important that you are able to feel the heat from the treatment fully, and be able and aware of how to look after skin post treatment.* |
| Are you currently, or have you used, Roaccutane,  Isotretinoins or Retin A in the last 6 months? | Yes | No | *If yes, wait 6 months after medication stops* |
| If yes to any of the above please list fully below: | |  |  |

## General Information (delete Yes or No or responses as applicable)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Have you had any chemical peels in  the last 4 weeks? e.g., AHA’s or dermabrasion | | | | Yes | No | If > 20% peel or dermabrasion wait 4 weeks  If < 20% peel or microdermabrasion wait 1 week | |
| Have you had any injectable fillers in  the last 6 months? e.g., collagen, restylane or Botox | | | | Yes | No | If yes, wait 6 months before treatment  For Botox, wait 1 month before treatment | |
| Do you suffer with any acute or chronic skin conditions in the treatment area? | | | | Yes | No | If yes, avoid the area during treatment | |
| Do you take any form of exercise? | | | | Yes | No | If yes, wait 24 hours after treatment | |
| Do you smoke? | Yes | No | If yes - High/Mod/Low | | | | ***Smoking and drinking can compromise collagen production post treatment*** |
| Do you drink alcohol? | Yes | No | If yes - High/Mod/Low | | | |

Before commencing treatment it is important for us to have as much information as possible to ensure that you do not have an adverse reaction to Collagen Lift ™ Treatment. We therefore ask you to advise us immediately, and prior to any treatment, if there are any changes to the above information.

## Proposed areas of concern(s) for treatment with Collagen Lift ™ (delete items not applicable)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Wrinkles | Skin laxity | Acne scarring | Cellulite | Scars | Stretchmarks |

**Areas to be treated: (add a ‘X’ in area(s) required)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Around eyes |  | Abdomen |  | Lower legs |  |
| Jowls |  | Hips |  | Thighs |  |
| Neck |  | Upper arms |  | Other areas: | |
| Decollete |  | Full arms |  |
| Full face |  | Buttocks |  |

## Treatment programme (Practitioner to complete ahead of Client signature)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Patch test prior to treatment (skin test) | 1. | | 2. |  | | |
| Post care recommendations: ( | | Given in writing as part of induction | | | Yes | No |
|  | | | | |
| Treatment course/Schedule recommended: | | | | | | |
| Do you have any questions regarding the treatment procedure? | | | | | | |
| Additional notes (Practitioner) | | | | | | |
| I certify that all of the statements and information given are true and correct and I understand and accept all terms and conditions.  **Client signature:**  **Date:** | | | | | | |

## Consent form By signing the Consent form below, you agree with the following statements

I understand that taking the treatment course is my choice and that I am free to withdraw at any time, without giving any reason

I have been fully informed about the possible side effects of the treatment including: skin redness (erythema) and warmth. Although these side effects are rare and expected to be temporary, any adverse reaction should be reported immediately.

I understand that not everyone is a successful candidate for this treatment and results may vary

I confirm that I have read and understood all of the information and will undergo the treatment out of my own free will

I believe that I have adequate knowledge upon which to base an informed consent

I affirm that all information provided by me is correct to the best of my knowledge

I authorise before, during and after the procedure(s) the taking of photographs to be part of my patient profile. Confidentiality will be maintained.

I agree to adhere to all post treatment advice and agree to follow these guidelines at all times during the treatment programme

I agree that no refunds will be given for treatments received. I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Client signature** |  |  |  |  |  |  | **Date** |
| **Practitioner signature** |  |  |  |  |  |  | **Date** |