Schenden's
medical day spa

# ENDERMOLOGIE HISTORY AND CONSENT

Client Name: _____ Age _____ Date of birth: MM/DD/YY

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Home❍ Cell❍ Work❍ Other❍ _____ Home❍ Cell❍ Work❍ Other❍ Email: _____

How did you hear about us? _____

Emergency Contact: _____ Phone: _____ Relationship: _____

## MEDICAL HISTORY

**Allergies:** ○ Latex ○ Cosmetics ○ Seasonal ○ Foods ○ Metal(s)

List any Medication allergies: _____ Other: _____

**Please List any medications taken:**

| Name | Dose | Last Taken | Name | Dose | Last Taken |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

**The following is a list of conditions that might be contraindicated or require medical clearance before receiving Endermologie treatment. Please indicate if you have any of the following:**

☐ Yes ☐ No Cancer or malignant tumors

☐ Yes ☐ No Skin disorder, inflammation, eruptions or infection

☐ Yes ☐ No Acute inflammation, infections

☐ Yes ☐ No Infectious progressive illness

☐ Yes ☐ No Unexplained calf pain, deep vein thrombosis etc

☐ Yes ☐ No Recent surgery and scars

☐ Yes ☐ No Pregnancy

Other: _____

## Consent for Endermologie™ Treatments

*Please Initial*

_____ I understand the nature and the purpose of this treatment, possible alternative methods of treatment, including no treatment, have been fully explained to me during my consultation. I understand that this procedure is not an emergency, nor is it medically necessary to improve or protect my physical health.

_____ I have filled out the history sheet correctly and accurately. I understand failure to inform the therapist of any conditions could affect treatment result.

_____ I understand that this technique may involve certain risks of minor, temporary bruising and the possibilities of sensitivity reaction. All risks have been fully explained to me and I accept them.

_____ I hereby give my consent to receive non-invasive Endermologie™ treatments and release Schenden's Medical Day Spa as well as the therapist(s) from any current or future claims with treatment(s).

_____ I understand that this procedure is not a replacement for weight loss, although weight and inch loss may occur during the treatments.

_____ I consent to photographs being taken to evaluate treatment effectiveness for medical education training, profession publications or sales purposes. No photographs revealing my identity will be used without my written consent. If my identity is not revealed, these photographs may be used and displayed publicity without my permission.

I acknowledge results vary from person to person and that no guarantees or assurances have been made at to the results that may be obtained. The lasting effects of my treatments will depend on my metabolism, hormones, eating and exercise habits.

The effects of my treatments are due to consistent treatments and completion of a scheduled program.

It is further recommended that after the series of Endermologie™ sessions are completed, I should return periodically for treatments to maintain circulation and toning of the skin.

I understand I will be charged a 50% fee if I cancel my appointment within 24 hours or do not show for my scheduled appointment.

*Client Signature*** _____ *Date* _____ *Technician Signature* _____ *Date* _____

*****If client is under 18- Signature of Responsible Adult Required*