VELASHAPE HISTORY AND CONSENT

Schenden's medical day spa

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: _____

***IF under 18: Information of responsible adult*

Name: _____ *Relationship To Client:* _____

Contact Phone: _____ *Signature/authorization* _____

MEDICAL HISTORY

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

List any Medication allergies: _____ Other: _____

☐ Yes ☐ No Have you had any aspirin or blood thinning products within the past 7 days?

Please List any medications taken:

Name	Dose	Last Taken	Name	Dose	Last Taken

Do you have or have you ever had any of the following :

☐ Yes ☐ No Metal implants

☐ Yes ☐ No Pacemaker/Defibrillator

☐ Yes ☐ No Impaired immune system

☐ Yes ☐ No Are you pregnant or Nursing?

☐ Yes ☐ No Diseases stimulated by light (e.g. Lupus, Epilepsy)

☐ Yes ☐ No Diseases stimulated by heat (e.g. Herpes Simplex)

☐ Yes ☐ No Endocrine disorders (e.g. diabetes, PCO)

☐ Yes ☐ No Use of medication / herbs inducing photosensitivity

If yes, Please list: _____

☐ Yes ☐ No Severe concurrent medical conditions (e.g. cardiac disorders)

If yes, Please list: _____

☐ Yes ☐ No Tattoo or permanent makeup

☐ Yes ☐ No Edema due to lymphatic drainage problem

☐ Yes ☐ No Tanned skin

☐ Yes ☐ No Active skin infection (e.g. psoriasis, eczema)

☐ Yes ☐ No Bleeding disorders /use of anticoagulants

☐ Yes ☐ No Skin disorders (e.g. keloids, abnormal wound healing)

Skin:

☐ Yes ☐ No Have you ever had skin cancer? If yes, where: _____

☐ Yes ☐ No Has anyone in your family had skin cancer? If yes, who: _____

☐ Yes ☐ No Do you have a history of skin disease? If yes, what: _____

Do you develop skin rashes in reaction to: ☐ Food ☐ Medication ☐ Environment ☐ Light

List any other diseases or conditions: _____

List any surgical procedures you have had within the past 6 months: _____

PRE-TREATMENT PREPARATIONS **Technician Use**

Fitzpatrick skin type **I** **II** **III** **IV** **V** **VI** **Ethnicity** _____

Degree of cellulite _____ **Weight** _____

Measurements _____

Treatment sites _____

Consent for VelaShapes™ Treatments

I, _____ , authorize Schenden's Medical Day Spa together with designated clinician, _____ , to perform VelaShapes™ treatment on the above treatment sites.

I understand the procedure is purely elective.

- I understand that the Vela*Shape* is a device used for improving the appearance of cellulite and reducing circumferences and that it may also be therapeutic for improving circulation and muscle aches in the treated areas.
- I understand there is a possibility of short-term effects such as discomfort, reddening, blistering, scabbing, temporary bruising and temporary discoloration of the skin, as well as rare side effects such as scarring and permanent discoloration.

These effects have been fully explained to me. _____ (patient's initials)

- I understand that treatment with the VelaShape involves a series of treatments and the fee structure has been fully explained to me.

The series and fee structure have been fully explained to me. _____ (patient's initials)

- I understand that clinical results may vary depending on individual factors, including but not limited to medical history, skin type, patient compliance with pre/post treatment instructions, and individual response to treatment.
- I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and I understand that no guarantee can be given as to the final result obtained.
- I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so.
- I confirm that I have informed the staff regarding any current or past medical condition, disease or medication taken.
- I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit, education and promotion. *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 certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form.

The procedure as well as alternative treatment, potential benefits and risks have been explained to my satisfaction. I have had all my questions answered. I freely consent to proposed treatment(s).

Patient Signature Date Technician Signature Date