Client Consultation Card

Name

Home Address

Date of Birth

Doctors' Name and Address

Phone number Mobile number

Email Address

To help us get a better understanding of your skin concerns please answer the questions below, giving brief additional details where necessary.

Medical History Please state if you have any of the following conditions:

Heart conditions or Pacemaker or any other electrical devices	Yes ○	No ○	Diabetes	Yes ○	No ○
Metal plates or pins in the area (artificial hip joints etc.)	Yes ○	No ○	Epilepsy	Yes ○	No ○
Cancer	Yes ○	No ○	Very high blood pressure	Yes ○	No ○
Endocrine/hormonal disorders such as Hyperthyroidism	Yes ○	No ○	Muscle paralysis		
Deep vein thrombosis, varicose veins, Inflammation of the veins, phlebitis	Yes ○	No ○	Excessive or very apparent surface vascular presence	Yes ○	No ○
Psychological disorders (referring mainly to schizophrenia)	Yes ○	No ○	Blood thinning, anti-coagulant medication	Yes ○	No ○
Pregnancy and/or breastfeeding	Yes ○	No ○	Rosacea or Excessive dilated capillaries	Yes ○	No ○
Skin diseases and infections	Yes ○	No ○	Fillers and Botox	Yes ○	No ○
Cuts, abrasions, bruises	Yes ○	No ○			

If you have ticked yes to any of the above, please provide further details

Medication Please give details of any medication you are currently taking, providing the reason/dose:

Your Skin

Please state if you are currently using any Retinol/Retin A/Steroids/Active products such as Vitamin C on your skin Yes ○ No ○

If you answered yes please provide more detail

Have you had any skin peels in the past month? Yes ○ No ○

If yes, please state which type of peel and the strength

Have you had any IPL or Laser treatments in the past month? Yes ○ No ○

If so, please state the area(s) treated

When were you last in the sun or on a sunbed?

When will you next be in the sun or on a sunbed?

Treatment Plan

Date							
Number in course							
Assessment (Photographic evidence assessment/ comments)							
Whole face or area of the face							
Settings							
Time treated							

This declaration is to confirm that your therapist has fully explained the effects, and possible side effects of Meso Lift Pro. It also confirms that you have answered the medical questionnaire thoroughly and will update your therapist throughout your course should your health status or medication change.

Signed Date

Please print name

Therapist Signature

carlton professional