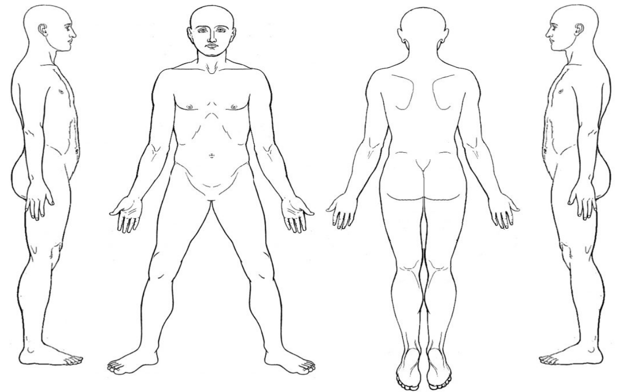
Ultrasonic Cavitation

Intake Form

Personal Information:

Name________________________________ Phone (Cell)__________________ (Home)_______________________
Address ______________________________________ City/State/Zip____
DOB________________ Email_______________________________ Occupation_________________________________
Emergency Contact______________________________ Relationship________________ Phone____________________
Sex: ☐ Male ☐ Female ☐ Other How did you hear about us?_______________________________________

What areas are in need of treatment? Please mark/circle:



Are you pregnant or nursing? ☐ Yes ☐ No
Are you epileptic? ☐ Yes ☐ No
Do you have any kind of tumor or cancer? ☐ Yes ☐ No
Do you have cardiac or vascular disease? ☐ Yes ☐ No
Do you have acute inflammation? ☐ Yes ☐ No
Do you have wounds that are not healed? ☐ Yes ☐ No
Do you have a history of internal bleeding? ☐ Yes ☐ No
Do you have a pacemaker or electrical device? ☐ Yes ☐ No
Have you had any abdominal operations? ☐ Yes ☐ No
Do you have high/low blood pressure? ☐ Yes ☐ No
Do you have hemophilia? ☐ Yes ☐ No
Do you have thrombosis? ☐ Yes ☐ No
Do you have melanoma? ☐ Yes ☐ No
Have you undergone a transplant? ☐ Yes ☐ No
Do you have a neurological disorder? ☐ Yes ☐ No
Do you have any keloids? ☐ Yes ☐ No
Do you have any heart conditions/disease? ☐ Yes ☐ No
Do you have any current infections? ☐ Yes ☐ No
Do you have an infectious disease? ☐ Yes ☐ No

Do you have any advances or untreated diabetes? ☐ Yes ☐ No
Do you have liver, kidney, or heart disease? ☐ Yes ☐ No
Are you taking recreational drugs? ☐ Yes ☐ No
Have you had recent cosmetic surgery? ☐ Yes ☐ No
Please explain any that are marked **YES**:______________
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____

What are your goals?(ex.loose body fat, cellulite reduction):
____
____

Thank you for choosing Medical Massage Clinic, Inc. A Healthy Heart and liver are required for these procedures. No metal Instruments can be present during these scheduled treatments. Please see your Medical professional before beginning any services if you have heart or liver problems, uncontrollable high blood pressure and or cancer/radiology treatments within 30 -days of this treatment. If you have a pacemaker we cannot do ANY sound procedures.

I understand that by signing this agreement I am beginning a series of treatments to help reach the goals of my body contouring and spot fat reduction. I understand that individual results vary and that I must commit to changing the dietary and lifestyle factors necessary to achieve optimal results.

I understand the first step to positive change is creating awareness about the steps necessary to reach goals, and will work diligently to ensure success. I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I realize there may be pre-existing medical conditions that can preclude me from seeing optimal results. By signing this agreement I release the clinic/spa, Manufactures and distributors from any liability regarding this treatment and do so understanding that results can vary from one individual to the next.

AFTER CARE FOLLOW UP

You must continue a healthy Lifestyle which includes exercise, good diet, and daily intake of water. We also recommend that you maintain semi annual visits to insure you maintain your ideal weight loss. Please continue to follow the regime as directed by your personal physician. Should you begin to gain your weight back, please give us a call.
540-785-7888

I the customer declare I am 18 years old and did in fact consult with a doctor within the last 12-24 months. I understand that the use of any light or sound is at my own risk and release and discharge Medical Massage Clinic or and Manufactures or distributors held liable.

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained to me. My questions have been answered to my complete satisfaction. I have been urged and have been given all the time I need to read and understand this form.

I agree to honor my therapist the respect of their time. If I need to cancel my appointment for any reason I will give a 24 hour notice. If I fail to do so I will be charged $40.

Patient Signature____ Date_____________________

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