Nadia's Beauty

Cryolipolysis Consultation Form

Client Name:	**Address:**
Date of Birth:	**Post Code:**
Gender: Male Female	**Telephone No:**
Occupation:	**E-Mail:**
Practitioner Name:	**Date:**

Health and Lifestyle

Contraindications			**Do you have any of the following**		
Liver/Kidney Disease	YES	NO	Hyper or Hypotension	YES	NO
Heart Conditions inc. Pacemaker	YES	NO	Scarring history, fibrosis or seborrhoea	YES	NO
Silicosis or other Lung Conditions	YES	NO	Haemophilia or other clotting disorders	YES	NO
Cancer (Radiotherapy/Chemotherapy)	YES	NO	Epilepsy	YES	NO
Reynaud's Disease (or other vaso constrict disorders)	YES	NO	Diabetes	YES	NO
Physical Hypotonic	YES	NO	Thyroid Condition	YES	NO
Cardiovascular Disease	YES	NO	Hormonal Imbalances	YES	NO
Cerebral Disease	YES	NO	Other immune disorders not listed	YES	NO
Immune System Disease (i.e. AIDS or HIV)	YES	NO	Received or donated organ transplants	YES	NO
Urticarial or other immune disorders	YES	NO	Psoriasis or eczema in treatment area	YES	NO
Hypoproteinaemia	YES	NO	Keloid/hypertrophic scar in the region	YES	NO
Frostbite Intolerance	YES	NO	High Cholesterol	YES	NO
Hernia or weak stomach muscle walls	YES	NO	Thrombosis (past or present)	YES	NO
Severe diabetes	YES	NO	Broken Bones	YES	NO
Recent invasive surgery (in the last 12 months)	YES	NO	Undiagnosed swelling or inflammation	YES	NO
Artificial Implants (bone, etc)	YES	NO	Bruising, cuts or abrasions (treatment area)	YES	NO
Metal Plates or Joint Implants	YES	NO	Fever	YES	NO
Sites of prior cosmetic surgery	YES	NO	Menstruation	YES	NO
			Any other conditions not listed	YES	NO
			If yes please list:		
Pregnant or Breastfeeding	YES	NO			
Currently under the influence of drugs or alcohol	YES	NO			

If you have answered yes to any of the above, please give full details:		
Are you currently taking any medication?	YES	NO
If yes, please list all medications		

How is your sleep pattern? Good Average Poor			No. of Hours Sleep per night:	
How is your diet? Good Average Poor			How much water do you drink per day?	
Do you drink alcohol?	YES	NO	If yes, how many units per week?	
Do you smoke?	YES	NO	If yes, how many cigarettes per day?	
Do you exercise?	YES	NO	How often do you exercise per week?	

Have you ever had cryo body contouring or any fat removal or similar treatments before? If yes, please give details below including the type of treatment and the area.	YES	NO
Are you fully committed to making the relevant changes to get the best possible results	YES	NO

from your treatment?		

Informed client consent to cryolipolysis treatment

I, …….. consent to, and authorise, the Qualified Practitioners of Yorkshire Advanced Aesthetics LTD to carry out cryolipolysis treatments as discussed and agreed.

The areas to be treated are: ……..

• The treatment has been fully explained to me. I understand that this treatment can take up to 12 weeks for maximum results to be visible. I have been advised that results vary from person to person and that results will also depend on how well I follow my aftercare advice. ☐

• I understand multiple treatments will be necessary to achieve satisfactory results. I have been advised that the usual number of treatments vary from between 1 – 3 on most body areas. ☐

• I agree to follow all the aftercare advice as provided by my therapist (namely drinking lots of water, regular body brushing, following a healthy diet and partaking in regular exercise). Whilst I understand that the results from the treatments vary considerably, I accept that all treatments are to be carried out in good faith with the best possible achievable outcome observed. ☐

• I understand that there is a risk of some side effects including but not limited to, reddening, bruising, tenderness, and in more severe cases there is a risk of frostbite or ice burns. I accept these risks are possible and do not hold the therapist or company responsible for any adverse reactions that may occur from treatment. ☐

• I have asked all relevant questions appertaining to this treatment and am satisfied with the explanation and information given to me regarding the possible side effects and outcome of cryolipolysis. ☐

• I have been given full pre and post treatment advice and understand and agree to follow these guidelines at all times during the treatment programme. ☐

• In the unlikely event of an adverse reaction, I will advise the salon/clinic within 24 hours and, in the cases or frostbite or ice burns, will contact my GP to obtain medical advice. ☐

• I confirm that I am over the age of 18 years ☐

• I confirm that I have read and agree to all the guidelines and recommendations of this Informed Consent Form. ☐

Client Signature: …… Date: ……

Practitioner Signature: …….. Date: ……..