Endermologie *by LPG*

We request that you provide the information below to assist us in your evaluation and give us direction for recommended course of treatment for your particular needs. The information provided will be treated confidentially. We have determined that the more information we have, the better able we are to assist you in achieving your ultimate Endermologie goals.

Last Name ________________________________ First Name ________________________________ Middle Int. __________

DOB ____________________ Sex __________ Email ____

Contact Number (1)________________________________ (2)________________________________

Occupation/Employer____

Name, Contact Number and Relationship of a Person to contact in case of Emergency

____

____

How did you hear about us? ____

Referring Doctor/contact number____

Do you have written referral from referring doctor? Yes or No (please obtain by date for first appointment via fax or in person)

What brings you in to see us? If applicable, please list areas that have had a surgical procedure.

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General Medical Information:

Are you taking any medications or supplements? Yes or No

If Yes, please list and for what condition it relates to:

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Are you currently under the care of physician? Yes or No

If yes, for which condition are you being treated and the Physician providing the care?

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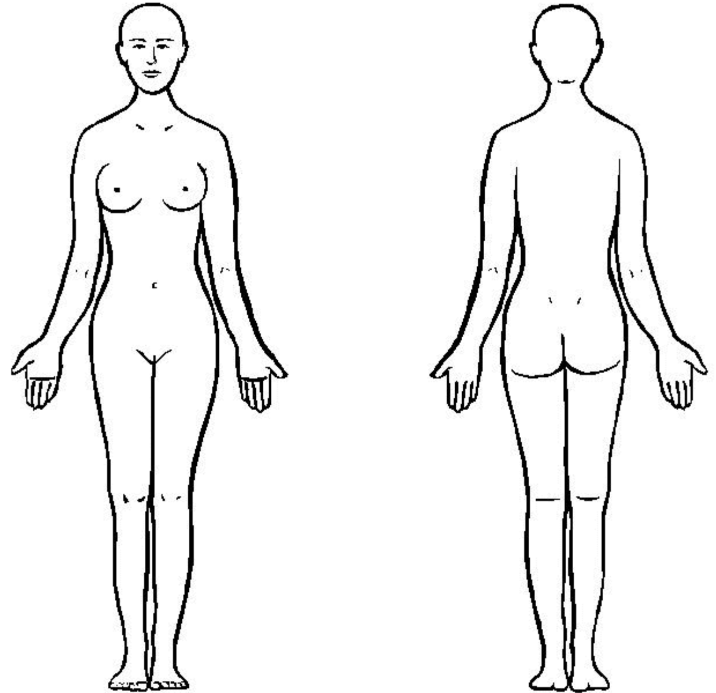
Specific Health Questions:

Have you ever been treated for, diagnosed as having, or are you currently suffering from any of the following:

*Contraindications for this treatment: please speak to your treating doctor before starting this procedure. Written referral required at that time.

1. *Skin tumors, skin cancer or melanoma **Y or N**
2. *Cancer? **Y or N**
3. *Any generalized skin disorder, inflammation, eruption or infection? **Y or N**
4. *Any infectious progressive illness, such as Hepatitis B, Acquired Immune Deficiency Syndrome or other conditions? **Y or N**
5. Any circulation disorder? **Y or N**
6. Neuromuscular/Neurological disorder such as seizures, etc? **Y or N**
7. Suffered from fainting, convulsions, recurrent headaches, dizziness, paralysis, stroke, nervous disorder or mental disorder? **Y or N**
8. Active rheumatoid arthritis? **Y or N**
9. Osteoporosis? **Y or N**
10. High blood pressure? **Y or N**
11. History of heart disease? **Y or N**
12. Phlebitis within the last two years? **Y or N**
13. Deep vein thrombosis and/or unexplained calf pain? **Y or N**
14. *Anti-coagulant medication? **Y or N**
15. Diabetes? **Y or N**
16. History of bilious attacks? **Y or N**
17. Recent major surgery (less than 2 months)**Y or N**
18. Are you pregnant?**Y or N**
19. Liposuction or cosmetic surgery within the last 6 months?**Y or N**
20. Skin disorder, open sores, inflammation eruption or infection? **Y or N**
21. Abnormal skin sensitivity? **Y or N**
22. *Scars from surgery or skin graft (less than 2 months)?**Y or N**
23. Keloids? **Y or N**
24. New stretch marks (less than 2 months)? **Y or N**
25. Varicose veins/capillary/vascular problems? **Y or N**
26. Diabetes? **Y or N**
27. Allergies? **Y or N**
28. Have you received any injections (collagen, cortisone, etc.)? **Y or N**
29. Muscle, nerve or joint disorder? **Y or N**
30. Have you recently started contraceptive pills? **Y or N**
31. Cesarean sections? **Y or N**
32. Are you under hormonal treatment? **Y or N**
33. Do you suffer from Pre-Menstrual Syndrome? **Y or N**
34. Do you have normal menstrual cycles? **Y or N**
35. Are you taking Anti-Depressant medication? **Y or N**
36. Do you have sensitive skin or bruise easily? **Y or N**
37. Are you sensitive to cold temperatures? **Y or N**
38. Are you taking medication for venous problems? **Y or N**
39. Do you suffer from constipation? **Y or N**
40. Are you taking laxatives? **Y or N**
41. Are you taking diuretics? **Y or N**
42. Do you drink alcohol? **Y or N**
    How many glasses daily, weekly or monthly? _________
43. Do you smoke? **Y or N**How many cigarettes daily? _________
44. Have you been on a diet/weigh lost program in the last year? **Y or N**
45. When did you start noticing the appearance of cellulite?__________
46. Where do you have cellulite?

Indicate cellulite location below ***or*** *the areas indicated by your doctor for treatment:*



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Explain below each question answered "YES"

Question #   Explanation

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Client Consent for Treatment:

I hereby request, authorize and consent to allow Tri-County Spine and Rehab to administer Endermologie® technique on my person. I acknowledge that this technique and the alternatives to this technique have been fully explained to me. I have had the opportunity to ask questions and my questions have been answered to my satisfaction. ______________________(initials)

I have fully disclosed my medical history and completely answered all specific health questions. ______________________(initials)

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

I am aware that the results achieved by this treatment may vary from person to person, and I acknowledge that no promises or guarantees have been made to me as to the results of this treatment. ______________________(initials)

Being aware of the preceding, I hereby knowingly and voluntarily consent to the above described treatment.

____ ____________________________

Patient Signature Date

Thank you for choosing us to be a part of you wellness.

Endermologie® was originally developed in France in the 1980s as a treatment for adherent scars. (Adherent scars result when the skin is damaged by repeated infection or ulceration, so that scar tissue becomes attached to the skin's underlying layers.) Endermologie® was developed as an alternative method to surgery for freeing the scar.In the process of freeing the scar tissue, many patients observed reduction of body dimensions and improvement in skin texture. Since then, Endermologie® has been used as a treatment to achieve cellulite reduction, skin toning and all around connective tissue repair.

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Treatment Notes

Initial Consult/First visit Notes:

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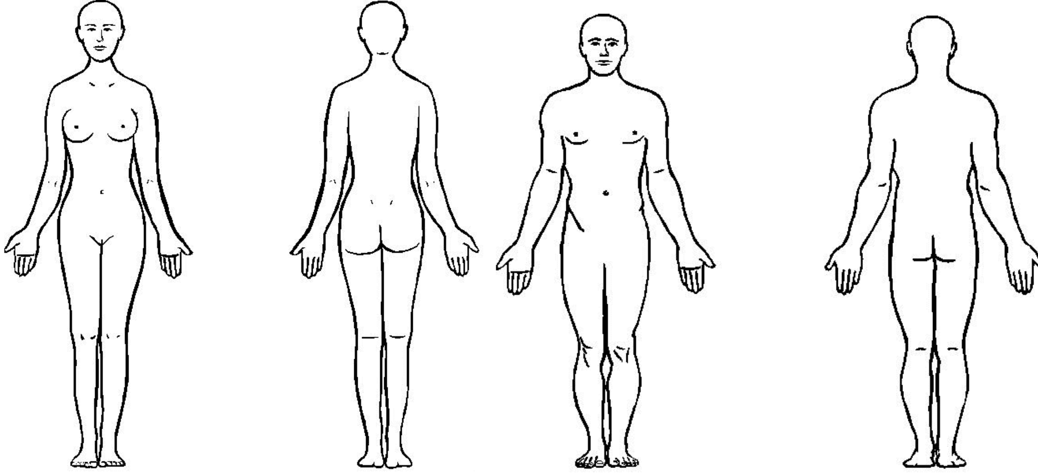
____

Areas of concentration:



Date	*Power levels*	*Area*	*Therapist initials*

Tri-County Spine and Rehab4904 Wunnenberg Way, West Chester, Ohio 45069phone 513-671-6713 fax 513-671-6718

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Date	*Power levels*	*Area*	*Therapist initials*

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