NEW YOU
Health and Wellness

Cavitation, Skin Tightening & LLLT Lipo

Personal Information

Date: _____

Last Name:_____ **First Name:**_____

Date of Birth: _____/_____/_____ **Cell Phone #:** (_____)_____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Email Address: _____

Name and Number of Emergency Contact: _____

How did you hear about us: _____

Medical History

Please check the medical conditions you are or have experienced in the past

_____ **Problems with Seizures**

_____ **Contagious or Infectious disease**

_____ **Heart Problem (including pacemaker)**

_____ **Undergone a Transplant**

_____ **Cancer (unless in remission for over 6 yrs)**

_____ **Liver Disease**

_____ **Kidney Disease**

_____ **Pregnant or Nursing**

_____ **Any Metal Implants**

Client Certification

I certify that the preceding medical, medication and personal history statements are true and correct. I am aware that it is my responsibility to inform the medical professional of my current medical conditions and to update this history if there are any changes in the future.

SIGNATURE: _____ **Date:** _____

WITNESS: _____ **Date:** _____