

Consultation and Consent form

Patient information

Full Name			
Date of Birth		Email	
Contact Number		Address	

Medical History

Current Medications	
Known Allergies	
Previous Surgeries/Treatments	
History of Skin Diseases (e.g., acne, eczema)	

Skin Assessment

Skin Type (Oily, Dry, Combination, Sensitive)	
Areas of Concern (e.g., wrinkles, fine lines, dark circles)	
Current Skincare Routine	
Family History of Skin Conditions	
Frequency of Sun Exposure	
Use of Sunscreen	

Lifestyle and Habits

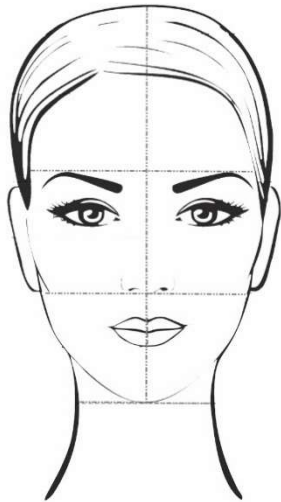
Alcohol consumption	
Diet and Nutrition	
Exercise Routine	
Stress Levels	
Sleep Patterns	

Previous Treatments and Results

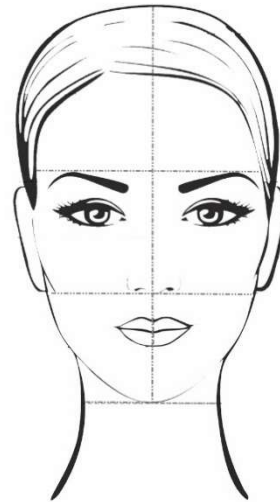
Last skin/face Treatment	
Date of the treatment	
Satisfaction with Previous Treatments	
Side Effects Experienced	

Treatment Goals

Desired Outcomes	



Client concerns



Consultant observations

Consultant Notes

To be filled out by the consultant during the consultation	
Skin Analysis	
Treatment Plan	
Recommended Products	

CONTRAINDICATIONS FOR WONDER FACE TREATMENT

Do you have any of below listed absolute contraindications? If yes, you are non-eligible for Wonder Face treatment.

- ☐ Pregnancy & lactation
- ☐ Pacemaker or electronic implants
- ☐ Active infections, open wounds, or skin conditions (eczema, psoriasis, dermatitis, etc.)
- ☐ Cancer or history of cancer
- ☐ Uncontrolled diabetes
- ☐ Severe neurological disorders (e.g., epilepsy)
- ☐ Blood clotting disorders (e.g., thrombosis, hemophilia)
- ☐ Recent facial surgery (post 6 weeks)
- ☐ Metal implants in the treatment area
- ☐ Rosacea is contraindicated only for Radiofrequency
- ☐ Melasma is Contraindicated only for Radiofrequency
- ☐ NONE OF THE ABOVE

Do you have any of below listed relative contraindications? If yes, consultation with a doctor is required

- ☐ Botox or other injectables (within 2 weeks prior to treatment)
- ☐ Skin sensitivity or history of keloids
- ☐ History of migraines triggered by electrical stimulation
- ☐ Use of anticoagulant medications
- ☐ Recent sunburn or laser treatment in the target area
- ☐ Autoimmune diseases affecting skin health
- ☐ NONE OF THE ABOVE

Client Declaration & Consent

By signing below, I confirm that:

- ☐ I have provided accurate information regarding my medical history and health conditions
- ☐ The treatment has been explained to me, including its benefits, risks, and possible side effects.
- ☐ I understand that mild redness, tingling, or temporary muscle soreness may occur post-treatment.
- ☐ I acknowledge that results may vary and that multiple sessions may be required for optimal results.
- ☐ I consent to taking pre- and post-treatment photographs for evaluation purposes
(optional: ☐ Yes ☐ No).
- ☐ I take full responsibility for my decision to undergo this treatment and release the clinic and its professionals from any liability arising from known or unknown reactions.
- ☐ I have the right to refuse or discontinue the treatment at any time.

Client Signature		Date:	
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Practitioner Signature:		Date:	
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