Secret RF

CONFIDENTIAL CLIENT ASSESSMENT AND TREATMENT RECORD

Name: _____ Gender: ☐ M ☐ F

Address: _____ Age: _____

_____ Weight: _____

Phone: _____ Height: _____

MEDICAL HISTORY / PATIENT ASSESSMENT

What skin concerns does the patient have? _____

_____

_____

What would the patient like to achieve from this treatment? _____

_____

_____

General Health: ☐ No issues ☐ Minor issues ☐ Chronic issues

Smoking History: ☐ Never Smoked ☐ Ex-smoker ☐ Light smoker ☐ Heavy smoker

Sun Exposure: ☐ Never use sun screen ☐ Occasionally use sun screen ☐ Always use sun screen

Does the patient have any of the following conditions?

Open facial wounds or lesions[1]	☐ YES	☐ NO
Keloid scars[1]	☐ YES	☐ NO
Implanted electrical devices[1]	☐ YES	☐ NO
Pregnant or lactating[2]	☐ YES	☐ NO
Suffers from migraines[2]	☐ YES	☐ NO
Suffers from Bell's palsy[2]	☐ YES	☐ NO
Haemorrhagic or bleeding disorders[1]	☐ YES	☐ NO
Mechanical or other implants in the treatment area[1]	☐ YES	☐ NO
Active or local skin disease that may alter wound healing[2]	☐ YES	☐ NO
Autoimmune Disease[2]	☐ YES	☐ NO
Any condition requiring the use of anticoagulants[1]	☐ YES	☐ NO
Herpes, shingles or cold sores[1]	☐ YES	☐ NO
Skin malignancy[1]	☐ YES	☐ NO

Does the patient have any allergies? If so, specify: _____

_____

Does the patient have any chronic illness? If so, specify: _____

_____

1: Secret[RF] may be contraindicated for use. Your practitioner will evaluate your suitability for treatment.

2: Secret[RF] has not been evaluated for use in this scenario.

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MEDICAL HISTORY / PATIENT ASSESSMENT (CONT'D)

HAS THE PATIENT UNDERGONE ANY OF THE FOLLOWING COSMETIC PROCEDURES IN THE BROW OR LOWER FACE AND NECK AREA?

Facial skin tightening procedure treatment within the last 1 year ☐ YES ☐ NO
Treatment name: _____ Location treated: _____ Date of last treatment: _____

Filler Injection within the last 3-6 months ☐ YES ☐ NO
Product Name: _____ Location treated: _____ Date of last treatment: _____

Neurotoxin Injection within the last 3-6 months ☐ YES ☐ NO
Product Name: _____ Location treated: _____ Date of last treatment: _____

Ablative resurfacing laser treatment ☐ YES ☐ NO
Treatment name: _____ Location treated: _____ Date of last treatment: _____

Non-Ablative resurfacing laser treatment ☐ YES ☐ NO
Treatment name: _____ Location treated: _____ Date of last treatment: _____

Dermabrasion or deep facial peels ☐ YES ☐ NO
Treatment name: _____ Location treated: _____ Date of last treatment: _____

Lipoplasty in the face or neck regions ☐ YES ☐ NO
Treatment name: _____ Location treated: _____ Date of last treatment: _____

Facelift or blepharoplasty or brow lift ☐ YES ☐ NO
Treatment name: _____ Location treated: _____ Date of last treatment: _____

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MEDICAL HISTORY / PATIENT ASSESSMENT (CONT'D)

MEDICATION

Is the patient taking any of following prescription medications?

Accutane within the last 12 months	☐ YES	☐ NO
Anticoagulants or antiplatelet drugs	☐ YES	☐ NO
Immunosuppressant drugs	☐ YES	☐ NO

List all medications and supplements below. Be sure to include all prescription or non-prescription medications.

If the patient is not taking any medications or supplements, please check here: ☐

MEDICATION	DISEASE / REASON	DOSE	FREQUENCY	DATE STARTED	DATE LAST TAKEN

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MEDICAL HISTORY / PATIENT ASSESSMENT (CONT'D)

SKIN CHARACTERISTICS

Please check the appopriate box for each of the questions below:

UPPER FACE	NONE	MILD	MODERATE	SEVERE
Skin Laxity and Quality: Excess skin or hooding on the eyelid; eyelid droopiness; fine lines; crepiness/wrinkling and/or poor elasticity				
Volume: Presence of fat deposits under the eyes; infra-orbital puffiness				
Scarring: Acne scars; chicken pox scars, surgical scars				
LOWER FACE AND NECK	NONE	MILD	MODERATE	SEVERE
Skin Laxity and Quality: Fine lines; crepiness/wrinkling and/or poor elasticity				
Volume: Presence of fat deposits in lower face, loss of jaw definition, and/or excessive sub-Q fat				
Scarring: Acne scars; chicken pox scars, surgical scars				

CLINICAL NOTES: _____

Patient's Signature: _____ Date: _____

Therapist's Signature: _____ Date: _____

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MEDICAL HISTORY / PATIENT ASSESSMENT (CONT'D)

TREATMENT CHECKLIST

Pre-treatment photos taken: ☐ YES ☐ NO

Procedure reviewed with patient: ☐ YES ☐ NO

Patient questions answered: ☐ YES ☐ NO

Informed Consent signed: ☐ YES ☐ NO

Photo Consent signed: ☐ YES ☐ NO

Secret^{RF} treatment date: ___/___/____

Pre-medication order: _____

Secret^{RF} treatment record printed from system: ☐ YES ☐ NO

Secret^{RF} patient record completed: ☐ YES ☐ NO

FOLLOW UP CHECKLIST

Aesthetic care plan discussed: _____

_____

_____

Three month follow-up appointment scheduled: _____

1st follow-up date: _____ Photos taken: ☐ FV ☐ R45 ☐ R90 ☐ L45 ☐ R90

2nd follow-up date: _____ Photos taken: ☐ FV ☐ R45 ☐ R90 ☐ L45 ☐ R90

CLINICAL AND TREATMENT NOTES:

_____

_____

_____

_____

_____

_____

_____

Patient's Signature: _____ Date: _____

Therapist's Signature: _____ Date: _____