

CONFIDENTIAL CLIENT ASSESSMENT AND TREATMENT RECORD

Name: _____ Gender: ☐ M ☐ F Age: _____ Weight: _____ Height: _____

Do you have any of the following conditions?

- | | | |
|--|------------------------------|-----------------------------|
| Active severe or cystic facial ACNE ¹ | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Open facial wound or lesion ¹ | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Metal stents in the treatment area ² | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Implanted electrical devices ³ | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Pregnant or lactating ³ | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Suffers from migraines ³ | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Suffers from Bell's palsy ³ | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Haemorrhagic or bleeding disorders ³ | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Mechanical or other implants in the treatment area ² | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Active or local skin disease that may alter wound healing ³ | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Autoimmune Disease ³ | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Epilepsy ³ | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Herpes or cold sores ³ | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Diabetes ³ | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

1: Ultraformer is contraindicated for use.

2: Ultraformer is not recommended for use directly over this.

3: Ultraformer has not been evaluated for use in this scenario.

MEDICATION

Are you taking any of following prescription medications?

- | | | |
|--------------------------------------|------------------------------|-----------------------------|
| Accutane within the last 12 months | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Anticoagulants or antiplatelet drugs | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Immunosuppressant drugs | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

HAVE YOU 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 | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Filler or Neurotoxin Injection within the last 3-6 months | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Ablative resurfacing laser treatment | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Non-Ablative resurfacing laser treatment | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Dermabrasion or deep facial peels | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Lipoplasty in the face or neck regions | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Facelift or blepharoplasty or brow lift | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

ULTRAFORMER

MEDICAL HISTORY / PATIENT ASSESSMENT (CONT'D)

SKIN CHARACTERISTICS

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

UPPER FACE	NONE	MILD	MODERATE	SEVERE
Skin Laxity: Excess skin or hooding on the eyelid; eyelid droopiness				
Volume: Presence of fat deposits under the eyes; infra-orbital puffiness				
Skin Quality: Fine lines, crepiness/wrinkling, and/or poor elasticity				
LOWER FACE AND NECK	NONE	MILD	MODERATE	SEVERE
Skin 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				
Skin Quality: Fine lines, crepiness/wrinkling, and/or poor elasticity				

CLINICAL NOTES:

Patient's Signature: _____ Date: _____

Therapist's Signature: _____ Date: _____

ULTRAFORMER

CONSULTATION RECORD (Clinician Use Only)

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

Ultraformer treatment date: _____

Pre-medication order: _____

FOLLOW UP NOTES

CLINICAL AND TREATMENT NOTES:

Patient's Signature: _____ Date: _____

Therapist's Signature: _____ Date: _____