# ULTRAFORMER

## 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] | ☐ YES | ☐ NO |
| Open facial wound or lesion[1] | ☐ YES | ☐ NO |
| Metal stents in the treatment area[2] | ☐ YES | ☐ NO |
| Implanted electrical devices[3] | ☐ YES | ☐ NO |
| Pregnant or lactating[3] | ☐ YES | ☐ NO |
| Suffers from migraines[3] | ☐ YES | ☐ NO |
| Suffers from Bell's palsy[3] | ☐ YES | ☐ NO |
| Haemorrhagic or bleeding disorders[3] | ☐ YES | ☐ NO |
| Mechanical or other implants in the treatment area[2] | ☐ YES | ☐ NO |
| Active or local skin disease that may alter wound healing[3] | ☐ YES | ☐ NO |
| Autoimmune Disease[3] | ☐ YES | ☐ NO |
| Epilepsy[3] | ☐ YES | ☐ NO |
| Herpes or cold sores[3] | ☐ YES | ☐ NO |
| Diabetes[3] | ☐ YES | ☐ 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 | ☐ YES | ☐ NO |
| Anticoagulants or antiplatelet drugs | ☐ YES | ☐ NO |
| Immunosuppressant drugs | ☐ YES | ☐ 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 | ☐ YES | ☐ NO |
| Filler or Neurotoxin Injection within the last 3-6 months | ☐ YES | ☐ NO |
| Ablative resurfacing laser treatment | ☐ YES | ☐ NO |
| Non-Ablative resurfacing laser treatment | ☐ YES | ☐ NO |
| Dermabrasion or deep facial peels | ☐ YES | ☐ NO |
| Lipoplasty in the face or neck regions | ☐ YES | ☐ NO |
| Facelift or plepharoplasty or brow lift | ☐ YES | ☐ NO |

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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:** 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:

2017.03.17

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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: _____