VALENCY HEALTH

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Ultrasound Cavitation Treatment

For the best treatment outcomes, please read and complete the following:

Name:_____ **DOB:**_____ **Age:**_____ **Height (cm):**_____
Address: _____
Email:_____
Phone: _____

1. **Do any of the following conditions currently apply to you? (tick all that apply)**

- ☐ Pregnant or Breast Feeding
- ☐ Compromised liver function (hepatitis, raised liver enzymes, fatty liver)
- ☐ Tendencies to bleeding (haemophilia, taking Warfarin or blood thinning medication)
- ☐ Pace maker or Cardiovascular disease
- ☐ High blood cholesterol/ triglycerides
- ☐ Epilepsy (medicated, or have had past seizures)
- ☐ Diabetes
- ☐ Acute illness (cold, flu, tummy bug)
- ☐ Cancer (previously diagnosed or current treatment for cancer)
- ☐ Past allergy or reaction to ultrasound gel (we use a hypoallergenic gel)

2. **Have you consumed at least three glasses of water today prior to your treatment?**

- ☐ Yes
- ☐ No, but I will have some now please

3. **What are your expectations for treatment/ your goals for treatment? (eg. target areas, weight loss of ?Kg)**

_____
_____
_____

4. **Please list ALL current daily medications/ herbs/ supplements and dose:**

_____
_____

5. **Are there any other medical conditions you have that your practitioner should be aware of:**_____

_____

Ultrasound Cavitation is a treatment that reduces fat cells in the area applied. Please be aware that results vary across individuals, but your practitioner is trained to help you get the best results from your treatment. If you are uncomfortable at any stage of the treatment please make your practitioner aware immediately.

Be aware that Ultrasound Cavitation uses sound waves and sometimes these can be heard through the body in the ears during treatment. You can be given music to listen to, reducing any discomfort the sound may cause.

Declaration:
The information I have given is true and complete, and I would like to go ahead with Ultrasound Cavitation treatment. I am aware that every safety measure will be undertaken by staff and may include refusal of my treatment if deemed unsafe. I understand what will occur during treatment, and take personal responsibility for my choice in receiving treatment.

Name:_____ Signed:_____ Date: _____
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