



Client Medical Consultation / Treatment Record

Title (Mr/Mrs/Ms/Miss):	GP Name & Surgery:	
Client Name:	GP Contact No:	
Address:	Tel Home:	
	Tel Work:	
	Tel Mobile:	
	E-mail Address:	
Postcode:	Age:	Gender (Male/Female):

How did you hear about us?:

Area of Concern:

Are you currently suffering from any of the following:

	Yes	No	Comment
Epilepsy			
Urine infection / Kidney Issues			
Diabetes			
Cancer			
Medical oedema			
HRT (Hormone replacement therapy)			
Contraceptive			Pill / Coil / Other
Any Liver problems or issues			
Auto immune disease			
Currently pregnant			
Gastric ulcers			
Any form of infection, fever or disease			
Cardio vascular conditions			(Thrombosis, phlebitis, hypotension, hypertension, heart conditions/disease)
Regular antibiotics/medications taken			If yes, please list....
Any condition already being treated by a practitioner:			
Use of recreational drugs or alcohol:			
List ALL medication / regular supplements that you are currently taking:			

Medilipo Client Medical Consultation / Treatment Record

Do you have any of the following:			
	Yes	No	Comment
Light sensitivity			
Thyroid Problems			
Any Metal/ Pins/ Plates/ Cosmetic implants			
Muscular/skeletal problems			Back aches / Pain / Stiff joints / Headaches
Digestive problems			Constipation / Bloating / Liver / Gall bladder / Stomach
Circulation problems			Heart / Blood pressure / Fluid retention / Varicose veins
Gynaecological problems			Irregular periods / PMT / Menopause
Nervous system			Migraine / Tension / Stress / Depression
HIV			

Lifestyle questions:			
	Yes	No	Comment
Last period dates:			
Job description			
Do you eat regular meals?			How many per day?
Do you eat in a hurry?			
Do you exercise?			PLEASE TICK: Occasionally Irregularly Regularly
Please list types of exercise:			
Do you take vitamin supplements?			If yes, please list...
Do you suffer allergies?			If yes, please list...
Do you smoke?			If yes, how many per day?...
Do you drink alcohol?			If yes, approximate units per week?..
Date of last visit to the Doctor:			

Please list any recent Operations / Fractures / Scars / Localised swelling:
(Within 3 months for fractures and 1 year for operations)

Client's consent for Medilipo Treatment

I have been informed in detail about the procedure, application and purpose of the Medilipo treatments. I have also been informed about possible side effects, the probable duration of the effects and limits of the effects. I was given an opportunity to ask questions about the treatment, side effects, duration of the effects and limits of the effects.

I was informed that the treatment can only be carried out on healthy persons. I herewith confirm that I have informed my therapist at consultation of any treatments I am undergoing or any prescribed medication that I am taking. In particular, I have been informed about the contraindications, i.e. physical conditions in which the treatment may not be used.

Contraindications for treatment with Medilipo are: Pregnancy, Breast Feeding, Pacemaker, Cancer, Epilepsy, Liver condition, Light sensitivity, including any medications that affects this.

I have also been informed that the effects of Medilipo can last for different periods of time. I understand that this depends on age, condition of skin and lifestyle. Individually the effects can last for a longer or shorter period. It is advisable to prolong the effects with a maintenance program in order to sustain the desired results.

I understand that **at least 8 treatments are required for Medilipo treatments in** order to obtain longer lasting results. I understand that the cost of treatment may increase or decrease from time to time. I understand that to get the best results I need to drink a minimum of 2 litres of water a day and try and work with the treatment.

I understand that the results of the treatments are entirely dependent on my present state of health and wellbeing. All individuals are different and may have different responses to treatment and the number of treatments required to achieve the desired result can vary from individual to individual. In view of the above, I understand that no refunds for programmes, courses or individual treatments undertaken will be given.

I have answered all questions, particularly about my medical history, to the best of my knowledge. I have no further questions about the Medilipo treatment. I consent to being treated with Medilipo.

Clients Signature: _____

Date:

Client Print Name: _____

Therapist Signature: _____

Date:

Contraindications explained.

- pregnancy radiation of the fetus or treatment over the uterus with pregnant women,
- precancerosis & malignant tumours (cancer or precancerous stages,
- photodermatitis or photo sensitivity (650 – 750nm),
- existing skin damage through sun or other UV light,
- thyroid area and other endocrinal glands,
- testicle area,
- Epiphysis area with children,
- pace maker,
- open fontanelles,
- during or following a treatment with immunosuppressive medication,
 - o chemotherapy,
 - o cortisone treatment,
- medications which increase photosensitivity (i.e medication containing arsenic, amiodin, resorcin-, phenothiazine derivates, nalidixic acid and tetracycline, sulphonamide, chloramphenicol, chlorpromazine, thiazide diuretic, tricyclic antidepressants, sulphonylurea – agents for the treatment of diabetes),
- epilepsy,
- acute feverish infection,
- direct irradiation to the eye and in the area of the orbital rim toward the eyeball,
- hyperthyreosis (thyroid hyper function),
- fresh injuries at the treatment area,
- skin infections or infections of the subcutaneous tissue (erysipelas or phlegmon).

The following medication and or food could rarely cause photosensitivity and/or reduce treatment results:

- non-steroid anti-inflammatory medication (NSAID),
- antihistamines,
- contraceptives (estrogens, progesterone)
- and natural photo sensitizers such as celery, fennel, caraway, chervil, coriander and others.