Cavitation Intake

DATE

Name | DOB | AGE

Address

Phone | Occupation

Email

Ultrasound Cavitation Treatment Area: Check all that apply

- ☐ Abdomen
- ☐ Arms
- ☐ Upper Back
- ☐ Calves
- ☐ Neck
- ☐ Waist
- ☐ Inner/Outer Thighs
- ☐ Hips
- ☐ Buttocks
- ☐ Lower Back

Medical Background: Check all that apply (past and present)

- ☐ Pregnant/Nursing
- ☐ Epilepsy
- ☐ Internal Bleeding
- ☐ High Cholesterol
- ☐ Cancer
- ☐ Cardiac/Vascular Problems
- ☐ Abdomen Operations
- ☐ Allergies to Zinc/Nickel
- ☐ Acute Inflammation
- ☐ Unhealed Wounds
- ☐ High/Low Blood Pressure
- ☐ Hemophilia
- ☐ Melanoma
- ☐ Transplant(s)
- ☐ Neurological Disorder
- ☐ Thrombosis/Thrombophlebitis
- ☐ Anticoagulants
- ☐ Keloids
- ☐ Infection
- ☐ Tuberculosis/Other Infectious Disease
- ☐ Pacemaker/Other Electronic Device
- ☐ Diabetes
- ☐ Heart/Kidney/Liver Disease
- ☐ Plastic/Bone Cement/Large Metal Implants
- ☐ Other Medical Condition _____
- ☐ Current Medications: _____
- ☐ Recreational Drug Use: _____

By signing below, you agree to the following:
I have completed this form to the best of my ability and knowledge and agree to inform my practitioner of any changes to the information listed on all pages of this cavitation intake form. I have been informed of and understand the contraindications to the requested treatments and agree that I do not have any condition(s) that would make the requested treatment unsuitable. I will inform my practitioner of any discomfort I may experience during the requested treatment to allow them to adjust accordingly. I agree to waive all liabilities toward my practitioner and the company in which I am voluntarily seeking services from for any injury or damages incurred due to any misrepresentation of my health history.

Patient Signature Date

Professional Signature Date