Butt Vacuum Client Intake Form

BEE LUXE
MED SPA

General Information

Name | Date of Birth

Address

City | State | Zip Code

Phone # | Email

Occupation

Emergency Contact Name | Phone #

Would you like to be added to our email list for specials and discounts? Yes ☐ No ☐

How did you hear about us?

Medical History

Please check all that apply: Temp:_____

- ☐ Bleeding Disorder
- ☐ Broken Bones
- ☐ Cancer/Tumor
- ☐ Cardiovascular Problems
- ☐ Diabetes
- ☐ Dislocations
- ☐ Epilepsy
- ☐ Fever
- ☐ Heart Disease
- ☐ Hernias
- ☐ Hives/Herpes/Shingles
- ☐ Infection
- ☐ Infectious Disease
- ☐ Insulin Monitor
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Metal Implants
- ☐ Organ Failure
- ☐ Pacemaker/Other Electronic Device
- ☐ Pregnant/Nursing
- ☐ Skin Disease
- ☐ Sunburn
- ☐ Transdermal Drug Delivery System
- ☐ Transplant(s)
- ☐ Ulcerated Skin
- ☐ Unhealed Wounds

Other: _____

Do you have any other medical conditions that we should know about? Yes ☐ No ☐

If yes, please list:

Are you currently taking any medications (including, but not limited to, blood thinners)? Yes ☐ No ☐

If yes, please list:

Do you have any allergies? Yes ☐ No ☐

If yes, please explain:

Have you had any surgery within the past 12 months? Yes ☐ No ☐

If yes, date, please explain:

Do you have any medical devices implanted including, but not limited to, hearing aids, a pacemaker, or hormonal pellets? Yes ☐ No ☐

If yes, please list:

When was the first day of your last menstrual cycle?

Do you use recreational drugs? Yes ☐ No ☐

If yes, please list:

Service Information

What concerns would you like addressed today?

Do you want to lose body fat? Yes ☐ No ☐

If yes, from what area:

Do you want to tighten skin on your body? Yes ☐ No ☐

If yes, from what area:

Do you want to reduce cellulite? Yes ☐ No ☐

If yes, from what area:

Please list your regular exercise habits:

Please describe your current dietary habits:

How many ounces of water do you drink daily?

By signing below, I agree to the following:

I have completed this form to the best of my ability and knowledge. I agree to inform the technician of any changes in the above information. I agree that I do not have any condition(s) that would make the requested treatment unsuitable. I will inform the technician of any discomfort I may experience at any time during my treatment to allow them to adjust accordingly. I agree to waive all liability toward my technician and the spa, Bee Luxe Med Spa for any injury or damages incurred due to any misrepresentation of my health.

Name Printed	Signature	Date

Butt Vacuum Informed Consent Form

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Vacuum therapy is a noninvasive massaging technique that utilizes a mechanical device equipped with vacuum-suction cups in order to increase lymphatic circulation and break down fatty deposits and cellulite and visibly lift and tighten your skin. Vacuum therapy is a non-invasive treatment with no downtime, however, as with any treatment, there are certain benefits and risks. Please read and initial each of the statements below:

_____ I certify I am over the age of 18.

_____ I have voluntarily elected to receive vacuum therapy after the nature and purpose of this treatment have been explained to me.

_____ I understand that vacuum therapy can be used to reduce fat deposits and cellulite but is not intended to be a weight loss solution.

_____ I recognize there are no guaranteed results.

_____ I understand that vacuum-suction cups will be used during this service. I understand that if I begin to feel uncomfortable, I will immediately inform my practitioner so that they may adjust accordingly.

_____ I understand and acknowledge that there are risks involved with the treatment I will be receiving including, but not limited to:

- Body Aches
- Bruising
- Discoloration
- Headache
- Irritation
- Mild discomfort
- Redness
- Nausea

_____ I understand that I should avoid hot showers, baths, sauna, hot tubs, and rigorous activity for 4-6 hours after my appointment.

_____ I understand that I should avoid caffeine, sugar, processed food and meats, and dairy after my appointment.

_____ I understand that it is important that I drink plenty of water after my appointment to help flush the toxins from my body.

_____ I understand that the payments for my service are non-refundable.

_____ I have been informed of possible benefits, risks, and complications, and I have had the opportunity to ask questions regarding these risks and other possible complications.

_____ I have, to the best of my knowledge, given an accurate account of my medical history, including all known allergies or prescription drugs or products I am currently ingesting or using topically.

I have read and fully understand this agreement and all information detailed above. I understand the procedure and accept the risks. I agree I will assume the risk and full responsibility for any and all injuries, losses, side effects, or damages that might occur to me while I am undergoing this procedure. I do not hold the practitioner responsible for any of my conditions that were present, but not disclosed at the time of this procedure, which may be affected by the treatment performed today.

_____ _____ _____

Name Printed **Signature** **Date**

Verified by: _____

By signing this release, I hereby waive and release Bee Luxe Med Spa from any and all liability, past, present, and future relating to bodywork.