NEUROTRIS
ADVANCED MICROCURRENT SCIENCE FOR ANTI-AGING

Body – Microcurrent Consultation Form

Name: Email Address:

Address:

City: State: Zip:

Business Phone#: Personal Phone#:

Referred By:

Age Range: 18-27 ☐ 28-37 ☐ 38-47 ☐ 48-57 ☐ 58-67 ☐ 68+ ☐

Date: Session: Date: Session:

***Please read:

By signing below, I certify that I have read this form in its entirety. I fully understand the following paragraph and I have had sufficient opportunity for discussion of any questions I may have. All the questions on this form are answered truthfully by me, and I understand that some conditions may be contraindications to receiving treatment.

I will address any and all concerns I may have with my skin care specialist prior to beginning the demo/treatment. I will accurately answer the questions below and disclose all known allergies, prescription drugs, conditions, or products I am currently ingesting or using topically that may affect my microcurrent treatment session. A-1 Engineering/NeurotriS & _____ will not be held responsible or accept any liability for injury or damages as a result of false information given or information withheld, this I acknowledge and except.

I understand this form must be filled out and signed by the customer wishing to begin a course of treatment. I give permission to my skin care specialist to perform the microcurrent procedure we have discussed. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures.

I understand my skin care specialist will take every precaution to minimize or eliminate negative reactions as much as possible. I understand that reactions are rare, but may include nausea, dizziness, weakness, and possible skin reactions including redness and/or other irritations. I understand that I may experience slight tingling sensations, flashing of the optic nerve, and/or a metallic taste in the mouth during the procedure. I understand that while the goal of this treatment is to improve the vitality of the skin, no specific guarantees of the result can or have been made.

All treatments will be performed by fully trained operators using the recommended skin care products.***

Client Signature: Date:

Skin Care Specialist Signature: Date:

1.Do you have any serious illness? YES / NO
Details:

2.Have you had any recent operations with general anesthetic? YES / NO
Details:

3.Do you have a pacemaker? YES / NO
Details:

4.Are you under any physical or psychological treatment? YES / NO
Details:

5. Do you suffer from a thyroid condition? YES / NO
Details:

6.Do you suffer from varicose veins? YES / NO
Details:

7. Do you suffer from water retention? YES / NO
Details:

8.Are you pregnant or trying to become pregnant? YES / NO
Details:

9.Are you epileptic or suffer from fits? YES / NO
Details:

10.Do you have any metal implants? YES / NO
Details:

11.Do you suffer from any skin conditions or have open wounds? YES / NO
Details:

12.Do you have any hormonal imbalance that you are aware of? YES / NO
Details:

13.Do you smoke? YES / NO
How many per day:

14. Do you eat from fast food restaurants regularly? YES / NO
How Often:

15. Do you consume an excess of carbohydrates, fats, and meats? YES / NO
Details:

16.What do you drink Coffee/Tea/Alcohol? YES / NO
_____ Cups coffee/tea per day. _____ Unit of alcohol per week.

17.How many glasses of WATER do you drink per day? YES / NO
Cups per day:

18. Do you include fruits and vegetables in your diet? YES / NO
How Often:

19. Are you taking any medication? YES / NO
Details:

20. Do you follow a regular exercise routine? YES / NO
How Often:

21. Do you have swollen feet? YES / NO
Details:

22. Have you ever had a tummy tuck or liposuction? YES / NO
Details:

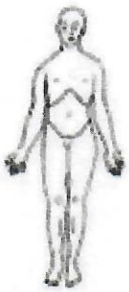
23. Have you ever had an adverse reaction to electrical treatment before? YES / NO
Details:

24. Any other relevant conditions/contraindications? YES / NO
Details:

CONTRAINDICATIONS

- Pacemaker
- Epilepsy
- History of seizures
- Metal Plates
- Pins in the area of treatment
- Diabetes (Ok With Physicians approval)
- Cancer (Ok With Physicians approval)
- Recent surgery
- Phlebitis / Thrombosis
- Spine Problems
- Pregnancy
- Recent Childbirth
- Any other medical problem should require a physician's approval letter signed (attached)
- Do not use to treat muscular pain, atrophy, multiple sclerosis etc. unless you are a licensed physician.

If your client has any medical, mental disorders or issues please use attached health form.

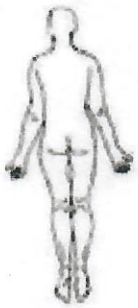


Therapist:_____

	BEFORE	AFTER
Bust/Chest:		
Arm (R):		
Arm (L):		
Diaphragm:		
Waist:		
Abdomen:		
Hips:		
Buttocks:		
Thigh (R):		
Thigh (L):		
Knee (R):		
Knee (L):		

Therapist:

	BEFORE	AFTER
Bust/Chest:		
Arm (R):		
Arm (L):		
Diaphragm:		
Waist:		
Abdomen:		
Hips:		
Buttocks:		
Thigh (R):		
Thigh (L):		
Knee (R):		
Knee (L):		



Date: _____ Session:_

Therapist:_____

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Date:_____ Session:_____

Therapist:

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Thigh (L):		
Knee (R):		
Knee (L):		

NOTES

Physicians Release Form To Allow SX Series Treatments A Microcurrent / Massager Device

A patient of yours, _____ is requesting SX Series Body Treatments. From_____.
Before we can proceed, we respectfully request your permission.
The SX Series Body System uses a (Biphasic Faradic Wave), delivered in the Micro Current range to stimulate a mild muscle contraction. The SX series is patented and FDA Class Registered. The SX Series is already being used in health clubs, Physicians practices, and beauty salons for those who want to lose weight without the strenuous effort.
Please sign and return for and on behalf of _____.
Client's Name

Feel free to call us with any questions you may have at _____.

_____ _____ _____
Sign Above Print Above Date