CLIENT FORM RMD - STRUCTURAL REMODELING SYSTEM

First Name ______________ Last Name ______________ BIRTH DATE (DD/MM/YYYY) __/__/__/

Address ______________________________ (Home) Phone ( ) ______________

CITY ______________/ PROVINCE ______________/ POSTAL CODE ______ ______

First visit date (DD/MM/YYYY) __/__/__/

PREVIOUS TREATMENTS

Results obtained / Reactions after treatment

Have you already received rejuvenation treatments? ______________ ______________	☐ Desired result obtained	☐ Desired result NOT obtained

Number of previous treatments ______________

Method used		**How your skin has reacted?**			
		Redness :		**Muscle spasms :**	
☐ HF (High Frequency)	☐ IPL	☐ Transient (disappeared in 24h)	☐ Sustained (disappeared in less than 3 days)	☐ Transient (disappeared in 24h)	☐ Sustained (disappeared in less than 3 days)
☐ Cosmetics	☐ Laser	**Edema :**			
Other methods: ______________		☐ Transient (disappeared in 24h)	☐ Sustained (disappeared in less than 3 days)	☐ Transient (disappeared in 24h)	☐ Sustained (disappeared in less than 3 days)

Other reactions : ______________________________

MEDICAL HISTORY

Are you suffering from following? (Check if Yes)				
☐ Diabetes	☐ Anticoagulants	☐ Pacemaker or other metallic or electric device	☐ HIV	☐ Paralysis or pain on the face
☐ Auto-immune diseases (ie. sclerodermia), or immunosuppressant medication	☐ Heart or blood problems (embolism, thrombosis, phlebitis, infarction, arrhythmias, reduced circulation, blood pressure etc.)	☐ Chronic skin diseases (eczema, psoriasis, etc.) infected skin, inflamed, or skin abnormalities	☐ Pregnancy or breastfeeding	☐ Recent surgery (last 3 months) (Date ________)
☐ Botox or injections (past 3 months) (Date ________)	☐ Severe acne or sensitive or fragile skin	☐ Epilepsy or convulsions	☐ Cancer or cancer treatment	

☐ Other medical conditions (explain)______________________________

Allergies : ☐ NO

☐ Metal (aluminum)	☐ Metal (aluminum)	☐ Metal (aluminum)	☐ Metal (aluminum)	☐ Metal (aluminum)	☐ Metal (aluminum)

I hereby declare having read the questionnaire and confirm that the written information is true and accurate

Client' Signature: ______________________________ DATE (DD/MM/YYYY) : ______/ ______/ ______/

SPA BEATRIX
705 430 2133