# Fat Dissolving Injections Consultation Form

## Provided by Aesthetic Amore

### Client Information

|  |  |
| --- | --- |
| Full Name: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Date of Birth: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Phone Number: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Email Address: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Address: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

### Medical History

|  |  |  |  |
| --- | --- | --- | --- |
| Condition | Yes | No | Comments |
| Pregnancy or breastfeeding | ☐ | ☐ |  |
| Allergies (e.g., lidocaine, soya-based products) | ☐ | ☐ |  |
| History of keloid scarring | ☐ | ☐ |  |
| Autoimmune diseases (e.g., lupus) | ☐ | ☐ |  |
| Liver or kidney disease | ☐ | ☐ |  |
| Active infections (e.g., acne, cold sores) | ☐ | ☐ |  |
| Blood-thinning medications (e.g., aspirin) | ☐ | ☐ |  |
| Diabetes or slow healing | ☐ | ☐ |  |
| Skin cancer or precancerous lesions | ☐ | ☐ |  |
| History of lipodystrophy or uneven fat distribution | ☐ | ☐ |  |
| Thyroid or hormonal conditions | ☐ | ☐ |  |
| Previous adverse reaction to injectables | ☐ | ☐ |  |

### Target Areas

Please indicate the areas you would like treated:

|  |  |
| --- | --- |
| Chin/Double chin | ☐ |
| Abdomen | ☐ |
| Flanks (love handles) | ☐ |
| Thighs | ☐ |
| Arms | ☐ |
| Back/Bra fat | ☐ |
| Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ☐ |

### Treatment Goals

|  |  |
| --- | --- |
| Describe your treatment goals: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Comments: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

### Pre-Treatment Checklist

|  |  |  |  |
| --- | --- | --- | --- |
| Requirement | Yes | No | Comments |
| No alcohol or blood-thinning medications in the past 48 hours | ☐ | ☐ |  |
| No retinoids or active skin products in the past 48 hours | ☐ | ☐ |  |
| No active skin infections or open wounds | ☐ | ☐ |  |
| Skin is clean and makeup-free | ☐ | ☐ |  |
| No major medical treatments in the past 14 days | ☐ | ☐ |  |

Do you understand and agree to the above requirements?

☐ Yes ☐ No

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Consent

|  |  |  |
| --- | --- | --- |
| Consent Statement | Yes | No |
| I confirm that I have provided an accurate medical history and understand the importance of disclosing relevant conditions. | ☐ | ☐ |
| I understand that fat-dissolving injections target localized fat and are not a weight-loss treatment. | ☐ | ☐ |
| I am aware of potential side effects, including swelling, bruising, redness, or tenderness. | ☐ | ☐ |
| I understand that multiple treatments may be required to achieve optimal results. | ☐ | ☐ |
| I consent to photographs being taken for medical records (☐ Yes / ☐ No) and/or marketing purposes (☐ Yes / ☐ No). | ☐ | ☐ |
| I confirm that I have received pre- and post-treatment instructions and will follow them. | ☐ | ☐ |

### Signatures

|  |  |  |
| --- | --- | --- |
| Client Signature | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Practitioner Signature | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

### Post-Treatment Instructions

• Avoid touching the treated area for 24 hours.  
• Apply a cold compress to reduce swelling if necessary.  
• Stay hydrated and maintain a healthy diet for best results.  
• Avoid alcohol, excessive sweating, or strenuous exercise for 48 hours.  
• Follow all aftercare instructions provided by the practitioner.