# Vacuum BBL Therapy Consultation Form

## Provided by Aesthetic Amore

### Client Information

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

### Medical History

|  |  |  |  |
| --- | --- | --- | --- |
| Condition | Yes | No | Comments |
| Cardiovascular issues or pacemaker | ☐ | ☐ |  |
| Recent surgeries (within 6 months) | ☐ | ☐ |  |
| Pregnancy or breastfeeding | ☐ | ☐ |  |
| Varicose veins or blood clotting issues | ☐ | ☐ |  |
| Skin infections or open wounds | ☐ | ☐ |  |
| Active skin conditions (e.g., eczema, psoriasis) | ☐ | ☐ |  |
| Use of anticoagulants or blood-thinning medications | ☐ | ☐ |  |
| Recent weight loss surgery or treatments | ☐ | ☐ |  |
| Allergies or sensitivity to suction therapy | ☐ | ☐ |  |

### Current Lifestyle and Goals

|  |  |
| --- | --- |
| How often do you exercise? | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you follow a balanced diet? | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you consume alcohol? (Frequency) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you smoke? (Yes/No) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| What are your goals for this treatment? | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you have any specific areas of concern? | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

### Pre-Treatment Checklist

|  |  |  |  |
| --- | --- | --- | --- |
| Requirement | Yes | No | Comments |
| No active skin infections or open wounds | ☐ | ☐ |  |
| No recent chemical peels or exfoliation treatments (within 7 days) | ☐ | ☐ |  |
| No use of retinoids or active skincare (within 48 hours) | ☐ | ☐ |  |
| No recent sunburn or tanning | ☐ | ☐ |  |
| Skin is clean and makeup-free | ☐ | ☐ |  |

### Consent

|  |  |  |
| --- | --- | --- |
| Consent Statement | Yes | No |
| I confirm that I have provided an accurate medical and skin history. | ☐ | ☐ |
| I understand that facials involve the application of skincare products, including cleansers, masks, and serums. | ☐ | ☐ |
| I am aware of potential side effects such as redness, sensitivity, or temporary irritation. | ☐ | ☐ |
| I understand that regular treatments and adherence to aftercare will help maintain results. | ☐ | ☐ |
| I consent to photographs being taken for medical records (☐ Yes / ☐ No) and/or marketing purposes (☐ Yes / ☐ No). | ☐ | ☐ |

### Signatures

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

### Post-Treatment Instructions

• Avoid sitting directly on the treated area for at least 24 hours.  
• Drink plenty of water to stay hydrated.  
• Wear loose, comfortable clothing to avoid irritation.  
• Avoid excessive sweating, hot baths, or saunas for 48 hours.  
• Follow all aftercare instructions provided by your practitioner.