

At Last...Salon & Day Spa  
 185 Park Row  
 Brunswick, Maine 04011  
 207-373-0751

**HIFU Intake Form**

NAME \_\_\_\_\_ HOME # \_\_\_\_\_ CELL # \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY, STATE&ZIP \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_ D.O.B. \_\_\_\_\_

Do you take blood thinners \_\_\_\_\_ if yes, did you stop at least a week ago? \_\_\_\_\_

Do you have any open sores or rash on areas that will be treated today? \_\_\_\_\_

Did you take Ibuprofen at least an hour before this treatment? \_\_\_\_\_

If you took aspirin, vitamin E or Fish oil in last week - please let me know as precaution

**DO NOT take any anti-inflammatory medications including Ibuprofen for the following 5 months. Acetaminophen (Tylenol) is acceptable.**

What areas are we treating today?

cheek/jawline		brow lift		cheek		chin	
marionette lines		upper lip		forehead		under eye/crows	
neck to jaw		jawline only		Body what part:			
neck only				Body what part:			

Have you had Botox or any fillers? \_\_\_\_\_ If so, how long ago? \_\_\_\_\_

Do you get facials regularly? \_\_\_\_\_ How often? \_\_\_\_\_

I understand the consultation that was conducted previously to this appointment and have read and understand all the directions given. I further understand that this service should not be construed as a substitute for medical treatment or diagnosis, and that I should see a physician, or other qualified medical specialist for any medical or physical ailment I am aware of. I acknowledge the results of this treatment are based on my post treatment measures and will reach out to At Last... if I have further questions.

I affirm that I have stated all my known medical conditions and answered all intake questions honestly.

Signed \_\_\_\_\_ Date \_\_\_\_\_