

## CLIENT INFORMATION CARD

Prepared especially for clients considering the VascuTouch™ treatments for removal of Telangectasias (distended capillaries, broken capillaries, etc.) on the face and upper body.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_ Age (optional): \_\_\_\_\_

Referred by: \_\_\_\_\_ Date of consultation: \_\_\_\_\_

I understand that although most cases of vascular blemishes are hereditary, there are several diseases that can cause the condition, and the vessels can be a vital diagnostic indicator.

Areas to be treated: (Please detail entry here)

\_\_\_\_\_  
\_\_\_\_\_

### Client Questionnaire:

How sensitive is your skin? \_\_\_\_\_

Are you currently under a physician's care? \_\_\_\_\_ Reason: \_\_\_\_\_

Are you pregnant or planning to be? \_\_\_\_\_

Do you have a heart condition? \_\_\_\_\_ Wear a pacemaker? \_\_\_\_\_

Do you have epilepsy or diabetes (if yes you need a MD certificate)? \_\_\_\_\_

Do you use anticoagulants (blood thinners)? \_\_\_\_\_

Please list any medications you are on:

\_\_\_\_\_  
\_\_\_\_\_

Have you visited a Dermatologist or any other skin care specialist about your Telangectasia?

*Please print name clearly:*

I \_\_\_\_\_ do fully understand all the questions above and have answered them correctly and honestly. Furthermore, I know that it is my responsibility to alert the clinician about any pre-existing conditions that may affect my treatment. Without the above disclosure I understand that the attending clinician cannot optimize the effectiveness of VascuTouch treatments. By signing below I consent to the VascuTouch treatment.

\_\_\_\_\_  
Signed by client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signed by technician

\_\_\_\_\_  
Date