ATLANT HEALTH
WELLNESS CENTER

## Microcurrent Health Questionnaire/Consent Form

Prior to receiving microcurrent, I have been candid in revealing any condition that may have a bearing on this procedure, such as:

- Pacemaker
- Epilepsy
- Active cancer
- Pins in the area of treatment
- Active Acne/ Eczema/Psoriasis/Rosacea
- Phlebitis
- History of Seizures
- Metal Plates
- Thrombosis
- Open sores/lesions/ broken or irritated skin
- Diabetes
- Pregnancy/Recent Childbirth

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**Please note:** This form must be complete and signed by the client wishing to begin a course of microcurrent treatment. All treatments will be performed by fully trained doctor.

All the questions will be answered truthfully by me _____(client name) and I understand that the above conditions may be contraindications to receiving treatment. Aleksander Kanevsky, DC, CFMP and his medical collaborators will therefore NOT accept any liability for injury or damages as a result of false information provided or being excluded.

Name: _____ Date of Birth:_____

Address: _____

Best Contact Phone Number: _____ Email address: _____

How did you hear about Atlant Health Wellness Center? _____

1. Do you have any serious illness:
   yes/no If yes, please explain: _____
2. Have you had any recent surgeries with general anesthetic? yes/no
   If yes, please explain: _____
3. Do you have a pacemaker?
   yes/no If yes, please explain: _____
4. Are you under any physical or psychological treatment?
   yes/no If yes, please explain: _____
5. Have you ever had cosmetic injections or Microdermabrasion? yes/no
   If yes, please explain: _____
6. Do you suffer from varicose veins?
   yes/no If yes, please explain: _____
7. Have you ever had laser treatments? yes/no If yes, please
   explain: _____
8. Are you pregnant or trying to get pregnant? yes/no
   If yes, please explain: _____
9. Are you Epileptic or do you experience seizures?
   yes/no If yes, please explain: _____
10. Do you have any metal implants?
    yes/no If yes, please explain: _____

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11. Have you suffered from any skin conditions? yes/no
    If yes, please explain: _____
12. Do you suffer from water retention? yes/no
    If yes, please explain: _____
13. Do you have any hormonal imbalances that you know of? yes/no
    If yes, please explain: _____
14. Do you suffer from a Thyroid condition? yes/no
    If yes, please explain: _____
15. Do you smoke? yes/no
    If yes, how many per day?: _____
16. Are you undergoing or have you had chemotherapy or radiation treatment? yes/no
    If yes, please explain: _____
17. Do you have low blood pressure, colds hands or cold feet? yes/no
    If yes, please explain: _____
18. Do you drink coffee/tea/alcohol/soft drinks? yes/no
    If yes, how many ounces of each per day?: _____
19. How many ounces of water do you drink per day? _____
20. Are you taking any medications or supplements? yes/no
    If yes, please list all that you are taking and dose: _____
21. Do you follow a skin care routine? yes/no
    If yes, which products are you using?: _____
22. Do you have any known ALLERGIES? yes/no
    If yes, please list: _____
23. Do you consider your skin sensitive? yes/no
    If yes, please explain: _____
24. Have you ever had an adverse reaction to electrical treatments before? yes/no
    If yes, please explain: _____

I understand that if I have any concerns, I will address these with my specialist. I give permission to my specialist to perform the microcurrent procedure we have discussed and **will hold** him/her and his/her company and medical collaborator **harmless and nameless from any liability that may result from this treatment**. I have accurately answered the questions above, including all known allergies, prescription drugs, conditions, or products I am currently ingesting or using topically. I understand my specialist will take every precaution to minimize or eliminate negative reactions as much as possible. In the event I may have additional questions or concerns regarding my microcurrent therapy, I will consult my specialist immediately. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read, and fully understand, the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered. I understand the procedure and accept the risks. I do not hold the specialist, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this procedure, which may be affected by the treatment performed today.

Client name (Print): _____
Client name (sign): _____
Date: _____

Specialist:_____