SALEM COSMETIC CLINIC

For all your cosmetic needs

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ANTI OBESITY DRIVE

Patient Consultation Form

Patient Name: Age/Gender:

Date:

Weight: BMI:

Availability for Treatment?
(circle preferences)

M	Tu	W	Th	F	Sa
Morning		Afternoon		Evening	

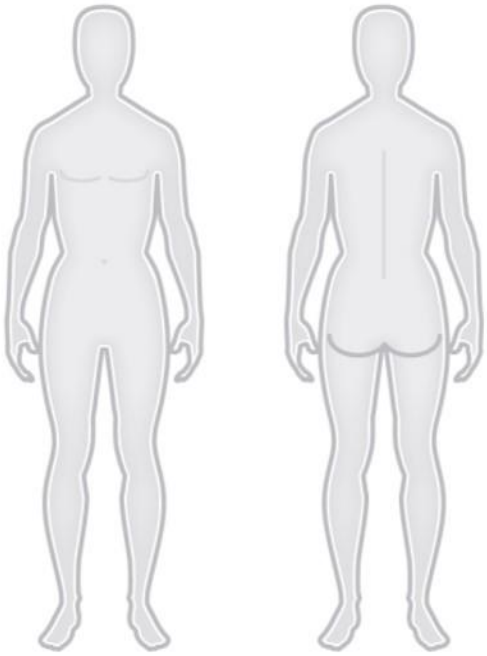
GOALS:

Patient Goals and Timeline

_____

_____

ASSESSMENT:



TREATMENT PLAN

Dietary Modifications _____

Cryolipolysis _____

No and Area of Paddles _____

Ultrasonic Lipocavitation _____

Laser Lipolysis _____

Radiofrequency Liporeduction _____

HIFEM Sessions _____

Infrared Sauna _____

Total cycles:

SPECIFIC Concerns:

PRICING:

Total Transformation Package

Retail Price:

Patient Price:

Patient Savings:

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Schedule of Procedures

Procedure / Session	Proposed Date	Procedure Date	Remarks
Cryolipolysis 1			
U lipo / Laser lipo 1			
U lipo / Laser lipo 2			
U lipo / Laser lipo 3			
Cryolipolysis 2			
U lipo / Laser lipo 4			
U lipo / Laser lipo 5			
U lipo / Laser lipo 6			
Cryolipolysis 3			
RF Lipo / HIFEM 1			
RF Lipo / HIFEM 2			
RF Lipo / HIFEM 3			
RF Lipo / HIFEM 4			
Infrared Sauna			