

Customer:

Completed: 13 Feb 2026 - 1:21 PM

Email:

Device Name: Website

Phone:

IP Address: 188.30.140.161

Business Logo:

Location: London GB



## Body Sculpting Consultation & Consent Form

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Body sculpting treatments are designed to contour, firm, and refine the body by targeting stubborn fat deposits, improving skin tone, and enhancing natural body shape using clinically selected techniques and medical-grade technology. Each treatment is tailored to individual body goals and specific concern areas, and may include non-invasive fat reduction, lymphatic drainage, skin-tightening procedures, electrical muscle stimulation, or combination therapies for optimal contouring and smoothing. A comprehensive consultation is required before any body sculpting treatment to ensure safety, suitability, and effective results. During this assessment, your medical history, body composition, lifestyle habits, and treatment expectations are carefully reviewed to determine the most appropriate approach and to identify any contraindications. Providing accurate and honest information is essential to minimise risks, prevent complications, and develop a safe, personalised body sculpting plan that delivers realistic and sustainable results.

## 1. Client Demographic Information

First Name: Rizwana

Last Name: Naswer

Address: 108 primrose road, London, Greater London, E18 1rb

Email: Rizwanar@live.co.uk

Phone: 07402528498

Gender: Female

Birth Date: 13 Feb 1975

Referred by: Groupon

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## Medical History & Skin Analysis

**2. Are you currently under the care of a doctor or dermatologist?**

No

**3. If "Yes" please specify**

Not Answered

**4. Do you have any of the following conditions? Please answer truthfully, this ensures your treatment is safe and effective**

Other medical condition

**5. If "Yes" to any of these including current medication" or "Other Medical Condition", please specify**

Asthma

## CONTRAINDICATION CHECK

Please read carefully. Some conditions listed below are absolute contraindications, meaning treatment cannot be carried out under any circumstances. Others are relative contraindications, meaning treatment may still be possible but requires adjustment, additional precautions, or postponing the procedure. Declaring these honestly is essential to protect your safety, prevent complications, and ensure the practitioner can choose the safest and most effective treatment approach.

**6. Please tick all that apply**

None of the above

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**7. Treatment Selection - Please select the treatment you're booked for:**

Electrical Muscle Stimulation (EMS)

**8. Have you had any aesthetic treatment (facials, microneedling, injectables, etc) within the last 6 weeks?**

Micro needling - 1 month ago

**9. When is this appointment scheduled?**

13 Feb 2026

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**Client's Consent (Mandatory)**

**Photographs are taken before and after treatment for medical documentation and client records.**

## **10. Client Consent (Mandatory) Please confirm each statement:**

I confirm that I have read, understood, and agree to follow the pre- and post-treatment information guide provided with this consultation and consent form., I confirm that the information I have provided is accurate, and I have disclosed all relevant medical history and allergies., I understand the general risks associated with aesthetic treatments, including bruising, swelling, asymmetry, infection, or temporary discomfort., I understand that results vary between individuals and that I may require further treatment for optimal or maintained results., I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction., I understand that all aesthetic treatments provide temporary results and will naturally wear off over time, I consent to photographs being taken for my medical record, with optional separate consent for marketing below., I consent to the processing of my personal data in accordance with the clinic's privacy policy and understand I can withdraw consent at any time.

## **11. Photo & Marketing Consent.**

I do not consent to any use of my photos beyond my medical record., I consent to receive emails with offers and updates

## **12. Please sign and date to confirm that you have read, understood, and agree to the statements above.**



X Customer's Signature

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**13. Client's Name**

Rizwana Naswer

X Employee's Signature

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**15. Employee's Name**

Jennifer Eze

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**Practitioner Notes (For Internal Use Only)**

Assessment:

Batch Number & Expiry Date:

Treatment Given / Units Used: