BOTOX TREATMENT FORM

- This informed treatment form provides the client with written information regarding the risks and benefits of a Botox treatment.
- It serves as a supplement to the discussion you have with your doctor/healthcare provider.
- It's important that you fully understand this information, so please read this document thoroughly.
- If you have any questions regarding the procedure, ask your doctor/healthcare professional before signing the consent form.

CLIENT INFORMATION

Please fill in the information as required

Name: _____

Date of birth (YYYY/MM/DD): _____ Age: _____

Sex: ☐ Male ☐ Female ☐ Non-binary ☐ Prefer not to say

CONTACT INFORMATION

Phone number: _____ Home address: _____

Email: _____

(by providing my email, I agree to receive email reminders and other service-related communications.)

☐ I agree to receive health updates, promotions, and other educational and marketing-related communications.

In case of emergency, whom should we contact: _____

Relationship to emergency contact: _____

MEDICAL HISTORY

Please answer if you've ever suffered from any of the following conditions. If the answer is yes, please give details.

Do you have any known allergies to botulinum toxin or any of its ingredients?

☐ Yes ☐ No

Have you had Botox or other injectable treatments in the past 6 months?

☐ Yes ☐ No

Are you currently taking blood thinners (e.g., aspirin, warfarin) or any medications that affect blood clotting?

☐ Yes ☐ No

Have you ever suffered from any of the following conditions?

- Heart disease ☐ Yes ☐ No
- High blood pressure ☐ Yes ☐ No
- Convulsions ☐ Yes ☐ No
- Hepatitis ☐ Yes ☐ No
- Pyschiatric disorders ☐ Yes ☐ No
- Depression ☐ Yes ☐ No
- Diabetes/hypoglycemia ☐ Yes ☐ No
- Blood clotting and bleeding disorders ☐ Yes ☐ No
- Skin diseases ☐ Yes ☐ No
- Cold sores/shingles ☐ Yes ☐ No

Are you currently pregnant, planning to become pregnant, or breastfeeding?

☐ Yes ☐ No

Do you have a history of keloid scarring or poor wound healing?

☐ Yes ☐ No

Have you had any recent surgeries or cosmetic procedures on your face or neck?

☐ Yes ☐ No

If yes, please list all hospitalizations and surgeries with approximate dates: _____

_____

Are you currently taking any muscle relaxants or medications for nerve conditions?

☐ Yes ☐ No

Are you taking any medications (including aspirin, anti-inflammatories, or complimentary medicines?
If yes, please list them below.

☐ Yes ☐ No

_____

_____

Do you have any skin infections, rashes, or open wounds near the areas where Botox will be injected?

☐ Yes ☐ No

Have you received Roaccutane treatment in the past 12 months?

☐ Yes ☐ No

Do you suffer from any chronic respiratory issues (e.g., asthma or COPD)?

☐ Yes ☐ No

Have you taken any antibiotics in the last 3 days? If so, what type?

☐ Yes ☐ No

Do you have any autoimmune diseases or conditions affecting your immune system?

☐ Yes ☐ No

Are you currently taking any over-the-counter supplements or vitamins (e.g., fish oil, vitamin E) that can affect bleeding?

☐ Yes ☐ No

BOTOX EXPERIENCE AND CONCERNS

Have you ever been injected with Botox before?

☐ Yes ☐ No

If yes, how was your experience? Did you have any complications or side effects? _____

_____

_____

Do you have any questions or concerns regarding Botox?

☐ Yes ☐ No

TREATMENT AREAS AND DOSAGE

- [ ] I agree that, as discussed during my consultation, Botox will be administered to specific areas in this treatment.
- [ ] The dosage of Botox will be tailored to my individual needs and the treatment areas identified.

PRE-TREATMENT GUIDELINES

- Avoid taking aspirin or other non-steroidal anti-inflammatory drugs like Ibuprofen, Advil®, Motrin®, Nuprin®, Aleve®, Celebrex®, Fish oil, ginkgo biloba, St. John's Wort, and high doses of vitamin E for 7-10 days before the procedure—they increase the risk of bleeding and bruising in the treated area.
- Avoid alcoholic drinks at least 24 hours before (or after) the procedure
- Avoid waxing, bleaching, tweezing, or using hair removal products in the area that's about to be treated.
- If you have concerns about discomfort, take Tylenol (if not contraindicated) one hour before the appointment to help with it.
- Inform your provider if you have a history of Perioral Herpes to receive advice on antiviral therapy before treatment.
- Avoid sun exposure.
- Have a small meal portion or a snack before the appointment.

DAY OF TREATMENT

- Arrive at the clinic with a "clean face." Please do not wear makeup.
- You may experience a mild amount of tenderness or a stinging sensation following injection.
- Redness and swelling are normal. Some bruising may also be visible.
- You may experience some tenderness at the treatment site(s) that can last for a few hours or a few days.

POST-TREATMENT CARE INSTRUCTIONS

- Avoid saunas or anything that would cause sweating on the day of treatment
- Avoid any type of facial, Micorderm abrasion or massage for 14 days post-treatment.
- Do not touch or rub the treated area for two to four hours afterward.
- Use the injected muscles for 1-2 hours after treatment: practice frowning, raising your eyebrows, and squinting.
- Use sunscreen every day

INSURANCE INFORMATION

Please provide the following insurance information if applicable:

Insurance provider: _____

Policy number: _____ Group number: _____

Insured's name *(if different from patient)*: _____

CONSENT AND ACKNOWLEDGEMENT

My signature below confirms that:

1. I have been informed, and I am fully aware, that small amounts of purified Botulinum toxin injected into a muscle cause weakness or paralysis.
2. I understand there are risks involved once I undergo this procedure. Some of these risks, if they occur, may necessitate hospitalization and/or extended outpatient therapy to permit adequate treatment. It has been explained to me that some of the risks include:
    - Post-treatment discomfort, swelling, redness, and bruising
    - Double vision
    - A weakened tear duct
    - Post-treatment bacterial and/or fungal infection requiring further treatment
    - Allergic reaction
    - Minor temporary droop of eyelid(s) in approximately 2% of injections, this usually lasts 2-3 weeks
    - Occasional numbness of the forehead lasting up to 2-3 weeks
    - Transient headache
    - Flu-like symptoms
3. I understand the information provided on this form and agree to all the statements made above.
4. I give permission and consent to the performance of administering Botulinum toxin (Botox) by [practitioner's name] and the medical staff at [clinic name].
5. I understand that there are no guarantees regarding the results or outcomes of the treatment.
6. My questions have been answered satisfactorily.
7. I understand that I have the right to discontinue the treatment at any time.
8. I authorize the taking of clinical photographs and videos and their use for scientific, educational, and marketing purposes both in publications and presentations.
9. I release [practitioner's name] and all medical staff at [clinic name] from all liabilities for any complications or damages associated with my Botox liabilities for complications or damages associated with my Botox treatment.

Disclaimer: *The Consent and Acknowledgment section included in this template serves just as an example. You should always consult legal counsel to help you create one in accordance with your practice needs.*

- I am the treating doctor/healthcare professional. I discussed the above risks, benefits, and alternatives with the patient.
- The patient had an opportunity to have all questions answered and was offered a copy of this informed consent.
- The patient has been told to contact my office for any questions or concerns after this treatment procedure.

Practitioner's name : _____

Practitioner's Signature: _____

Date: _____