CLIENT INFORMATION

DATE: _____

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

DOB: _____ EMAIL: _____

OCCUPATION: _____ ETHNICITY: _____

CELL: _____ WORK: _____ HOME: _____

HEIGHT: _____ WEIGHT: _____

How did you hear about us? _____

What area/s are you mostly concerned about? _____

I _____ (print) give the technician/s at Body Slimplicity permission to consult and evaluate me to determine whether I am a candidate for non-surgical body treatment.

DAILY INTAKE:

WATER	_____	How much	_____	Cups		DAILY	WEEKLY
COFFEE	_____	How much		Cups		DAILY	WEEKLY
ALCOHOL	_____	How frequent	DAILY	WEEKLY	MONTHLY	YEARLY	
TOBACCO	_____	How Many		Packs		DAILY	WEEKLY
FAST FOOD	_____	How frequent	DAILY	WEEKLY	MONTHLY	YEARLY	
SODA	_____	How much	_____	Cups		DAILY	WEEKLY

STRESS LEVEL:

AVERAGE	MODERATE	SEVERE

I consent to photos and measurements being taken and kept in my file.

X_____

I agree to allow Body Simplicity, LLC to use my photos for marketing purposes on Social Media and Websites.

X_____

Health History

Do you have a chronic medical condition? YES ☐ NO ☐

If so please indicate: _____

Have you had any surgeries? YES ☐ ☐

If so please indicate: _____

Do you have allergies to the following?

LATEX	YES	☐	NO	☐
MEDICATIONS	YES	☐	NO	☐
HERBAL SUPPLEMENTS	YES	☐	NO	☐

NATURAL SUPPLEMENTS YES ☐ NO ☐

If so please indicate: _____

Do you have or had any of the following?

EPILEPSY	YES	☐	NO	☐	
INFECTIONS	YES	☐	NO	☐	What?
SKIN DISEASE	YES	☐	NO	☐	What?
LOSS OF SKIN SENSATION	YES	☐	NO	☐	Where?
HERPES SIMPLEX	YES	☐	NO	☐	Last outbreak
AUTOIMMUNE DISEASE	YES	☐	NO	☐	What?
HEARING AIDS	YES	☐	NO	☐	
ANEMIA	YES	☐	NO	☐	
SICKLE CELL ANEMIA	YES	☐	NO	☐	
THROMBOSIS/ PHLEBITIS	YES	☐	NO	☐	
PACE MAKER	YES	☐	NO	☐	
HORMONE PELLETS	YES	☐	NO	☐	
METAL MEDICAL IMPLANT DEVICES	YES	☐	NO	☐	Where?
DIABETES TYPE 1 OR 2	YES	☐	NO	☐	Type?
TUMORS	YES	☐	NO	☐	
CANCER IN THE LAST 12 MONTHS	YES	☐	NO	☐	
CHEMOTHERAPY	YES	☐	NO	☐	
THYROID DISEASE	YES	☐	NO	☐	
HIGH BLOOD PRESSURE	YES	☐	NO	☐	
CARDIOVASCULAR DISEASE	YES	☐	NO	☐	
GALL BLADDER REMOVED	YES	☐	NO	☐	
HISTORY OF GALLSTONES	YES	☐	NO	☐	
KIDNEY PROBLEMS/ DISEASE	YES	☐	NO	☐	
LIVER PROBLEMS/PROBLEMS/ DISEASE	YES	☐	NO	☐	
COLON PROBLEMS PROBLEMS/DISEASE	YES	☐	NO	☐	
PREGNANT OR NURSING	YES	☐	NO	☐	
NECK/ BACK PROBLEMS	YES	☐	NO	☐	

Is there anything not listed we should know about? YES ☐ NO ☐

If so please indicate: _____

Have you had any recent changes in medical history? YES ☐ NO ☐

If so please indicate: _____

These forms have been completed truthfully to the best of my ability. If I fail to indicate history, I release liability from Body Slimplicity and/ or its agents for any post treatment symptoms or side effects. X_____