Date:\_\_\_\_\_\_

**CLIENT INTAKE FORM**

**Personal information:**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Day)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Evening)

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency Contact (Name/ Number)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The following information below will be used to help plan a safe and effective session. Please answer the questions to your best knowledge.

Date of initial visit and procedure\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you had this procedure done before? Yes No

If yes how long ago\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have any difficulties lying on your side, front and back? Yes No

If yes, explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have any allergies to oils, lotions or ointments? Yes No

If yes, explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have sensitive skin Yes No
2. Are you wearing Contact Lenses { } Dentures { } Hearing Aid(s) { }
3. Do you sit for long hours at a time at work or driving? Yes No

If yes, please describe

1. Are there any area(s) that you would like to see improvements? Yes No

If yes, identify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have any personal goals in mind for this session? Yes No

If yes, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**

In order to plan a safe and effective session, we will need some general information about your medical history.

1. Are you currently under medical supervision? Yes No

If yes please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you see a chiropractor? Yes No
2. Are you currently taking any medications? Yes No

If yes, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please CIRCLE below the conditions that applies to you.

Contagious skin condition YES NO Phlebitis YES NO

Open sores or wounds YES NO Deep vein thrombosis/blood clots YES NO

Easy bruising YES NO Osteoporosis YES NO

Recent accident/injury YES NO Epilepsy YES NO

Recent fracture YES NO Cancer (Year \_\_\_\_\_\_\_\_\_\_\_\_\_\_) YES NO

Accutane or Acne Treatment YES NO Diabetes YES NO

Sprains/strains YES NO Swollen Glands YES NO

Forehead/ Brow Lift YES NO Allergies/ Sensitivity YES NO

Back/Neck problems YES NO Heart condition YES NO

Fibromyalgia YES NO High or low blood pressure YES NO

Edema YES NO Blood thinner YES NO

Circulatory Disorder YES NO Botox (last treatment\_\_\_\_\_\_\_\_\_\_\_\_) YES NO

Atherosclerosis YES NO

Joint disorder/rheumatoid arthritis/osteoarthritis YES NO

**Pregnancy**

By signing here I attest that I am NOT Pregnant \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(sign/date)

Circle the areas you would like the contour specialist to focus on during each session.



Please explain any condition that you have marked above \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Is there anything else about your health that you think would be useful for Bodied by Shae LLC to know to plan a safe effective session for you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Please list all medications including supplements and herbs that you are currently taking.

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I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Print Name) attest that I am 18 or older and understand that the services I receive are provided for the basic purpose of body contouring and that individual results may vary. If I am in any pain or discomfort during the session, I will immediately inform the specialist. I further understand that body contouring should not be considered a substitute for medical examination, or any diagnosis treatment. I should see a physician or other qualified medical specialist for any other medical or physical illness, and that nothing said during should be construed as such. Because body contouring should be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the contour specialist updated as to any changes in my medical profile and understand that there shall be no liability on the part of the contour specialist or Bodied by Shae LLC should I fail to do so. I agree to hold harmless Bodied by Shae LLC employees and representatives.

I understand that there are NO REFUNDS for services or products.

Signature of Client \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Contour Specialist\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Office Use Only

Temp: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_