Self Empowered Beauty
420 East 81st Street, Suite #1, NY NY 10028
917-658-1660

PROFILE SHEET (For internal records Only)

NAME OF CLIENT_____ TODAY'S DATE_____

ADDRESS_____

CITY, STATE & ZIP_____

OCCUPATION_____ DATE OF BIRTH_____ SEX M☐ F☐

CELL_____E-MAIL_____

FULL NAME AT BIRTH(requested for Biofeedback): _____

PLACE OF BIRTH (requested for Biofeedback): CITY/STATE_____ COUNTRY _____

				If you answered YES to anything in this column, Microcurrent/Biofeedback should NOT be performed	
Number of cigarettes smoked per day		Number of alcohol drinks per day		Are you pregnant or possibly pregnant?	
Number of exercise sessions per week		Amount of sugar per day (1- minimal, 2- moderate, 3- excessive)		Do you have Epilepsy?	
Amount of toxic exposure such as radiation, chemicals, etc. (1- minimal, 2- moderate, 3- excessive)		Sensitivity to toxic exposure (1- minimal, 2- moderate, 3- excessive)		Do you have a pacemaker or heart condition?	
Stress Level (1- mild, 2- moderate, 3- severe)		Allergies (1- mild, 2- moderate, 3- severe)		Have you had fillers, botox or a chemical peel within the last 2 weeks?	

I understand that the attending practitioners are not allopathic doctors (MDs) and do not portray themselves to be but are providing biofeedback/micro-current and wellness services. I understand that the services provided identify energetic imbalances. Procedures utilized include stress reduction protocols, nutritional wellness consultation and biofeedback. I fully understand that the attending practitioners do not offer allopathic drugs, surgery, chemical stimulants, or any other conventional treatments. In addition, we do not diagnose, treat or otherwise prescribe for my disease, conditions or illness, or perform any act that would constitute the practice of medicine for which a license is required. I have solicited the attending practitioners' services in good faith, exercising my free will and following the dictates of my own conscience which allows me to select what I understand is most beneficial to my health. I am fully aware and release the practitioner to do biofeedback testing, wellness consultation and other stress reduction protocols. By signing below I acknowledge that I have read and understand all parts of this waiver, that I had the opportunity to ask any questions with regard to the described procedures, and that I hereby affirm: I am not here for medical diagnostic or treatment procedures and I am here on this and any subsequent visit solely on my own behalf.

_____ (initials)

CANCELLATION/RESCHEDULE POLICY (this information must be completed for the cancellation policy)
Cancellations/Rescheduling less than 2 days of the appointment will be charged the full appointment fee.

****** For best results, please make sure to drink 18oz water before your session***

Signature: _____ Print Name _____Date _____

Relationship to Client: ☐Self ☐Other _____ Would you like to receive relevant articles occasionally? ☐Yes ☐No

Is Client specified above a minor, under 18 years of age? ☐Yes ☐No Would you like to receive promotions occasionally? ☐Yes ☐No

Note: Self Empowered Beauty agrees to keep all client information including history, discussions, procedures and results obtained from the above services strictly confidential and may not be shared with anybody unless authorized in writing by the client.