

## BODY SCULPTING CLIENT INTAKE FORM

### General Information

Name \_\_\_\_\_ Birthday \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State/Province \_\_\_\_\_ Zip/Postal Code \_\_\_\_\_

Phone # \_\_\_\_\_ Email \_\_\_\_\_ Sex  M  F

Occupation \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone # \_\_\_\_\_

Would you like to be added to our email list for specials and discounts?  Yes  No

How did you hear about us? \_\_\_\_\_

### Medical History

Do you have any chronic medical conditions that we should know about?  Yes  No

If yes, please list: \_\_\_\_\_

Are you currently taking any medications?  Yes  No

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

Do you have any allergies?  Yes  No

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

Do you have type 1 or type 2 diabetes?  Yes  No

Do you have any known kidney or liver disorders?  Yes  No

Do you have photosensitivity to sun exposure?  Yes  No

Do you currently have cancer?  Yes  No

If yes, are you currently on chemotherapy?  Yes  No

Have you had cancer in the past 12 months?  Yes  No

Do you have any thyroid problems?  Yes  No

Do you have high blood pressure?  Yes  No

Do you have any cardiovascular conditions?  Yes  No

Do you have any medical devices implanted including, but not limited to, hearing aids, a pacemaker, or hormonal pellets?  Yes  No

If yes, please list: \_\_\_\_\_

What concerns would you like addressed today? \_\_\_\_\_

Do you want to lose body fat?  Yes  No

If yes, from what area: \_\_\_\_\_

Do you want to tighten skin on your body?  Yes  No

If yes, from what area: \_\_\_\_\_

Do you want to reduce cellulite?  Yes  No

If yes, from what area: \_\_\_\_\_

Please list your regular exercise habits: \_\_\_\_\_

Please describe your current dietary habits: \_\_\_\_\_

How many ounces of water do you drink daily? \_\_\_\_\_

(Female clients) Are you currently pregnant or nursing?

Yes No

When was the first day of your last menstrual cycle? \_\_\_\_\_

**By signing below, I agree to the following:**

I have completed this form to the best of my ability and knowledge. I agree to inform the technician of any changes in the above information. I agree that I do not have any condition(s) that would make the requested treatment unsuitable. I will inform the technician of any discomfort I may experience at any time during my treatment to allow them to adjust accordingly. I agree to waive all liability toward my technician and the salon for any injury or damages incurred due to any misrepresentation of my health.

Name Printed

Signature

Date

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_