

# 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 Simplicity 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
TOBACCO	_____	How Many	_____	Packs	MONTHLY	YEARLY
FAST FOOD	_____	How frequent	_____		DAILY	WEEKLY
SODA	_____	How much	_____	Cups	MONTHLY	YEARLY
					DAILY	WEEKLY

**STRESS LEVEL:**

AVERAGE	MODERATE	SEVERE
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**BODY SIMPLICITY**

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

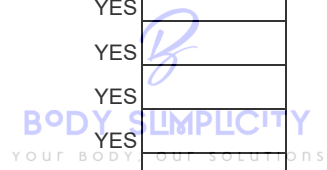
YES

NO

If so please indicate: \_\_\_\_\_

**Do you have or had any of the following?**

EPILEPSY	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
INFECTIONS	YES	<input type="checkbox"/>	NO	What?
SKIN DISEASE	YES	<input type="checkbox"/>	NO	What?
LOSS OF SKIN SENSATION	YES	<input type="checkbox"/>	NO	Where?
HERPES SIMPLEX	YES	<input type="checkbox"/>	NO	Last outbreak
AUTOIMMUNE DISEASE	YES	<input type="checkbox"/>	NO	What?
HEARING AIDS	YES	<input type="checkbox"/>	NO	
ANEMIA	YES	<input type="checkbox"/>	NO	
SICKLE CELL ANEMIA	YES	<input type="checkbox"/>	NO	
THROMBOSIS/ PHLEBITIS	YES	<input type="checkbox"/>	NO	
PACE MAKER	YES	<input type="checkbox"/>	NO	
HORMONE PELLETS	YES	<input type="checkbox"/>	NO	
METAL MEDICAL IMPLANT DEVICES	YES	<input type="checkbox"/>	NO	Where?
DIABETES TYPE 1 OR 2	YES	<input type="checkbox"/>	NO	Type?
TUMORS	YES	<input type="checkbox"/>	NO	
CANCER IN THE LAST 12 MONTHS	YES	<input type="checkbox"/>	NO	
CHEMOTHERAPY	YES	<input type="checkbox"/>	NO	
THYROID DISEASE	YES	<input type="checkbox"/>	NO	
HIGH BLOOD PRESSURE	YES	<input type="checkbox"/>	NO	
CARDIOVASCULAR DISEASE	YES	<input type="checkbox"/>	NO	
GALL BLADDER REMOVED	YES	<input type="checkbox"/>	NO	
HISTORY OF GALLSTONES	YES	<input type="checkbox"/>	NO	
KIDNEY PROBLEMS/ DISEASE	YES	<input type="checkbox"/>	NO	
LIVER PROBLEMS/PROBLEMS/ DISEASE	YES	<input type="checkbox"/>	NO	
COLON PROBLEM: PROBLEMS/DISEASE	YES	<input type="checkbox"/>	NO	
PREGNANT OR NURSING	YES	<input type="checkbox"/>	NO	
NECK/ BACK PROBLEMS	YES	<input type="checkbox"/>	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 Simplicity and/ or its agents for any post treatment symptoms or side effects. X \_\_\_\_\_