BODY SCULPTING

CONSULTATION FORM

CLIENT INFORMATION

Name: Date:

Date of birth: Age: ◯ Female ◯ Male

City: Zip:

Phone: Email:

Emergency contact: Phone:

MEDICAL HISTORY

Do you have or have you had any of the following conditions? If yes, please select them:

- ◯ Autoimmune disorder
- ◯ Blood clotting disorder
- ◯ Cancer/Chemo therapy
- ◯ Diabetes
- ◯ Epilepsi
- ◯ Gallbladder removed
- ◯ Gastrointestinal disorder
- ◯ Heart disease
- ◯ High blood pressure
- ◯ History of gallstones
- ◯ Infections
- ◯ Kidney disease
- ◯ Liver disease
- ◯ Photosensitivity
- ◯ Skin conditions
- ◯ Thyroid disorder
- ◯ Tumors
- ◯ Varicose veins

Any other condition?

Do you have any allergies to medications, products, or materials ?

Have you ever had an allergic reaction to any food or substance?

◯ No ◯ Yes .....

Have you had any recent surgery or injuries?

◯ No ◯ Yes .....

Do you have hearing aids, pacemaker, hormone pellets or any metal pins/plates implanted?

◯ No ◯ Yes .....

Do you currently experience any pain or discomfort in the areas you would like to target?

◯ No ◯ Yes .....

FEMALE CLIENTS

Are you pregnant or trying to become pregnant? ◯ No ◯ Yes

Are you breastfeeding? ◯ No ◯ Yes

YOUR LIFESTYLE

Are you currently on a weight loss program?

◯ No ◯ Yes .....

Do you exercise? If yes, how often?

◯ No ◯ Yes .....

Do you smoke? If yes, how often?

◯ No ◯ Yes .....

What is your alcohol consumption?

◯ I don't drink

◯ Once a month or less ◯ 2-4 times a month ◯ 2-3 times a week ◯ 4+ times a week

How much water do you drink daily?

◯ I don't drink water every day

◯ 1-2 glasses ◯ 3-4 glasses ◯ 5-6 glasses ◯ 7+ glasses

BODY SCULPTING GOALS

Have you undergone any previous body sculpting procedures?

◯ No ◯ Yes .....

What would you like to achieve?

◯ Eliminate excess fat ◯ Skin tightening ◯ Reshape/contour ◯ Cellulite removal

What specific areas of your body would you like to target for body sculpting?

◯ Abdomen ◯ Arms ◯ Thighs ◯ Buttocks

◯ Other: .....

What results are you expecting from the body sculpting procedure(s)?

.....

.....

I, the undersigned, confirm that I have disclosed my known medical conditions, provided honest answers to all questions, and agree to inform the provider of any changes in my medical history. I understand that the information provided is essential to ensure my safety during body sculpting treatments and that it will be kept confidential.

.....	.....	.....
Client name (printed)	*Client (signature)*	*Date*

.....	.....	.....
Technician name (printed)	*Technician (signature)*	*Date*