# 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 ☐ ☐
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? _____