# BODY CONTOURING
# CLIENT INTAKE FORM

APPOINTMENT DATE: _____ APPOINTMENT TIME: _____

| NAME: | AGE: | GENDER: |
|---|---|---|
| ADDRESS: | ZIP: | STATE: |
| EMAIL: | PHONE: | |

Opt-in for email list to receive information & offers: ◯ Yes ◯ No

How did you hear about us? ☐ Friends/Family ☐ Social Media Other: _____

Emergency contact: _____

## MEDICAL HISTORY:

***Current Conditions, Previous Discomfort, Stinging or Adverse Reactions:***

Please check all that apply:

- ◯ Arthritis
- ◯ Fever
- ◯ Hypertension
- ◯ Skin Disease
- ◯ Tuberculosis
- ◯ Bells Palsy
- ◯ Pregnant/Nursing
- ◯ Transplant(s)
- ◯ Acute Inflammation
- ◯ Melanoma
- ◯ Cancer/Tumor
- ◯ Infectious Disease
- ◯ Varicose Veins
- ◯ Under influence of drug
- ◯ High Triglycerides
- ◯ Kidney Disease
- ◯ Communicable Disease
- ◯ Neurological Disorder
- ◯ Cardiovascular Conditions
- ◯ Thrombosis or Thrombophlebitis
- ◯ Diabetes
- ◯ Organ Failure
- ◯ Heart Disease
- ◯ Liver Disease
- ◯ Unhealed wounds
- ◯ Epilepsy
- ◯ Metal Implants
- ◯ Pacemaker/Other Electronic Device
- ◯ High Cholesterol
- ◯ Dislocations

Other: _____

**The following information will be used to help plan safe and effective Body contouring sessions. Please answer the questions to the best of your knowledge.**

Do you have any allergies or infection? ◯ Yes ◯ No

If yes, please list: _____

Are you taking any medication currently? ◯ Yes ◯ No

If yes, please list: _____

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

If yes, please specify: _____

Do you use products containing retinol or AHA? ◯ Yes ◯ No

If yes, please specify: _____

Have you had any surgeries within the past 12 months? ◯ Yes ◯ No

If yes, please list: _____

If you are a female, are you currently menstruating? If not, when was the last day of your mensuration cycle? ◯ Yes ◯ No

Please list last date of the circle here: _____

Do you use recreational drugs? If so, when was the last time? ◯ Yes ◯ No

If yes, please list: _____

Have you had any skin problems in the past 4 weeks? ◯ Yes ◯ No

If yes, please list: _____

Have you recently had a chemical peel or microdermabrasion? ◯ Yes ◯ No

If yes, please specify date: _____

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

If yes, please list: _____

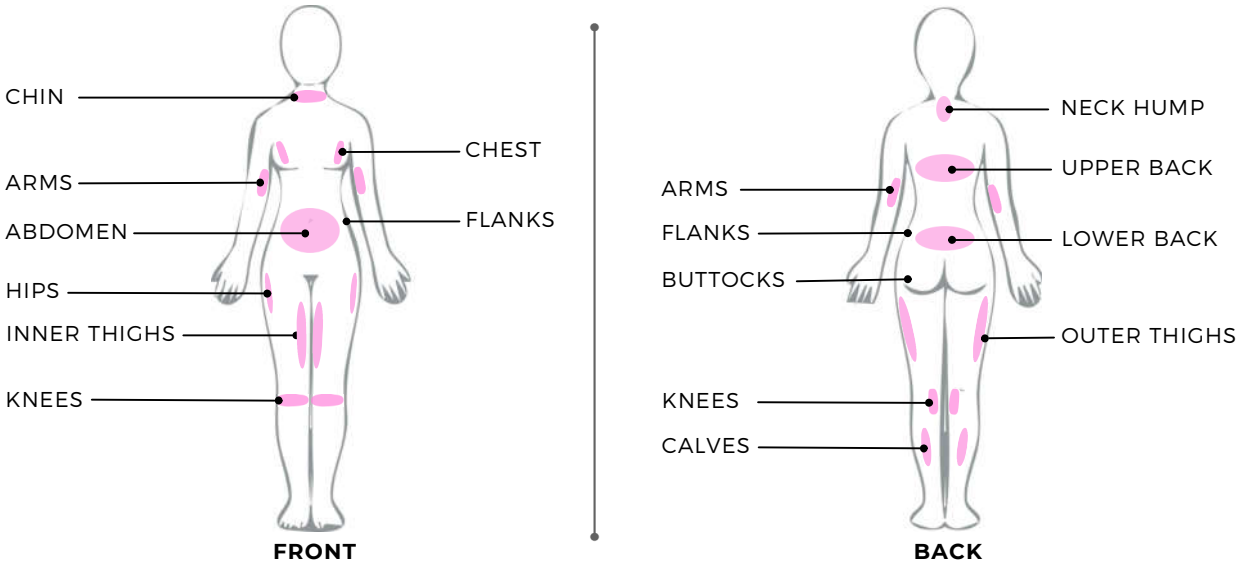
Please give us your current Weight: _____ Height: _____

What goals do you have for your body, and how fast are you looking to achieve them?

_____

_____

Please mark the area(s) with an (✖) you would like to see improvement:




I have completed this form to the best of my ability and knowledge, and agree to inform my therapist of any changes to the information listed on all pages of this intake form. I have been informed of and understand the contraindications to the requested treatments and agree that I do not have any condition(s) that would make the requested treatment unsuitable. I agree to waive all liabilities toward my therapist and " **AZ Med SPA** " for any injury or damages incurred due to any misrepresentation of my health history.

| Client Name (Printed) | Client Signature | Date |
|---|---|---|
| Therapist Name | Therapist Signature | Date |