

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:

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

Do you have diabetes, lupus, or any autoimmune disease? Yes No

Please specify: _____

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: _____

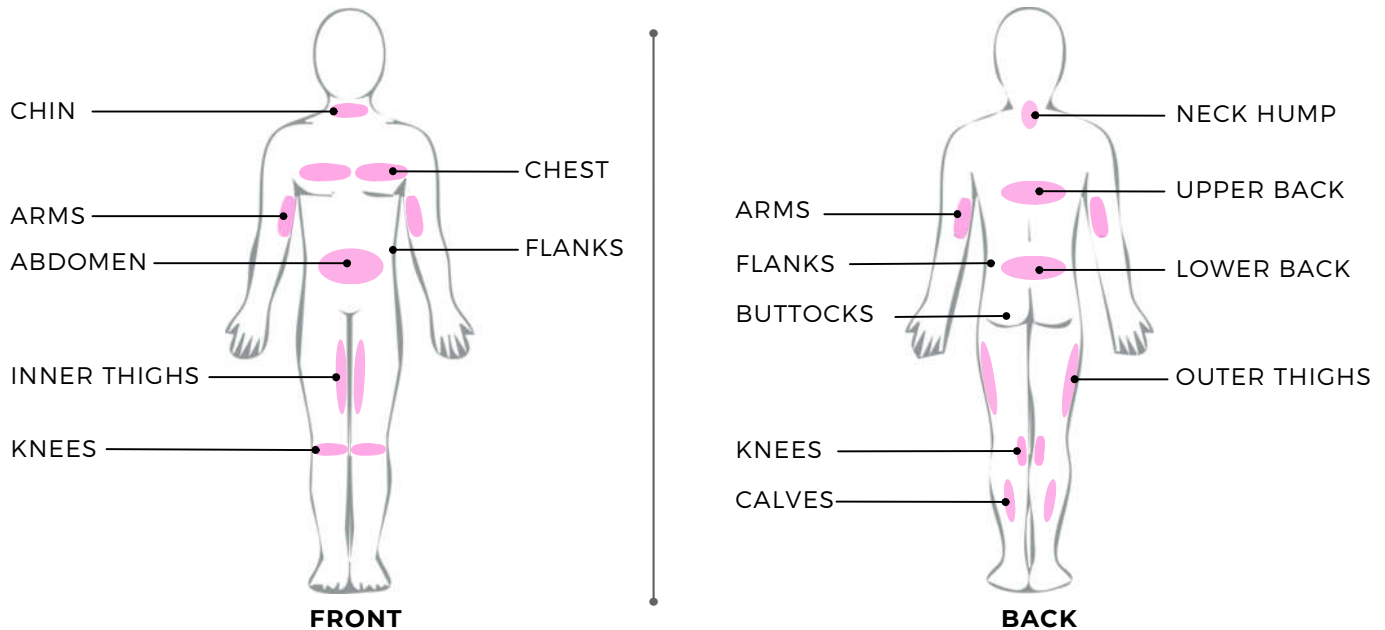
Do you have any implanted medical devices including but not limited to hearing aids, a pacemaker or hormonal pellets? Yes No

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 (X) 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 "**BUSINESS NAME**" for any injury or damages incurred due to any misrepresentation of my health history.

Client Name

Client Signature

Date

Esthetician Name

Esthetician Signature

Date

BODY CONTOURING

CLIENT CONSENT FORM

Although every precaution will be taken to ensure your safety and wellbeing before, during, and after the body contouring treatment, please be aware of the following information and possible risks.

Please Initial:

___ I have voluntarily elected to receive body contouring treatment after the nature and purpose of this treatment has been explained to me.

___ I understand that body contouring works by replacing fat cells with healthy ones, but is not intended to be a weight loss solution.

___ I understand that body contouring treatment does not treat medical conditions, nor does it claim or guarantee to treat or relieve any medical condition.

___ I understand that there are no guarantees that the treatment will be effective and that to ensure maximum results, multiple treatments will be necessary.

___ I understand that the following conditions preclude me from having this treatment at this time, and verify that none of the following conditions apply to me at this time:

- Cardiac issues Infected, inflamed, or swollen skin Cancer
 Pregnant/Lactating Metallic implant (pacemaker)

___ I have cited all conditions and circumstances regarding my health history, medications being taken, and any past reactions to products or medications.

___ I understand and acknowledge that there are risks involved with the treatment I will be receiving including, but not limited to:

- Redness Headache Bruising

___ I have been informed of possible benefits, risks, and complications, and I have had the opportunity to ask questions regarding these risks and other possible complications.

___ I have, to the best of my knowledge, given an accurate account of my medical history, including all known allergies or prescription drugs or products I am currently ingesting or using topically.

I have read and fully understand this agreement and all information detailed above. I understand the procedure and accept the risks. I agree I will assume the risk and full responsibility for any and all injuries, losses, side effects, or damages that might occur to me while I am undergoing this procedure. I do not hold the technician and the office responsible for any of my conditions that were present, but not disclosed at the time of this procedure, which may be affected by the treatment performed today.

By signing below, I verify that I have read and understand the above statements and agree to them.

Client Name (Printed)

Client Signature

Date