Integrated Body Contouring
815-439-2726 ~ 3583 Hennepin Drive Joliet, Il 60431

Client Intake Form

Name _____ Phone (Day) _____ Phone (Eve) _____
Address _____ City/State/Zip _____

Email _____ Date of Birth _____ Occupation _____

Emergency Contact _____ Phone _____

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.

Date of Initial Visit _____

1. Describe your weight/fat loss goals: _____
2. Have you had a professional, non invasive body contouring before? No Yes: (Circle all that apply) Laser-like Lipo/Ultrasonic RF/Cool Sculpting. Results:_____
3. Describe your current physical activity habits: None _____
4. Are you currently dieting? No Yes: Describe your diet: _____ Wt Lost:_____
4. Do you have any difficulty sitting, lying on your front, back, or side? No Yes: If yes, please explain _____
5. Do you have any allergies to oils, lotions, or ointments? Yes No If yes, please explain
6. Do you have sensitive skin? Yes No
7. Do you experience stress in your work, family, or other aspect of your life? No Yes: If yes, how do you think it has affected your health? Weight gain ( ) muscle tension ( ) anxiety ( ) insomnia ( ) irritability ( ) other _____
9. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? No Yes: If yes, please identify _____
10. Do you have any particular goals in mind for this body contouring session? No Yes: If yes, please explain Circle any specific areas of concern: Neck Back Arms Stomach Buttocks Thighs Calves
11. Are you generally in good health? Yes_____ No_____ Do you have any of the following health issues?

Cardiac Problems:

High Blood Pressure Yes ____ No____ Rapid Heart Rate Yes ____ No____ Heart Disease Yes ____ No____
Stroke Yes ____ No____ Circulatory Disorder Yes ____ No____ Heart Attack Yes ____ No____

Skin Disorders:

Skin Cancer Yes ____ No____ Psoriasis Yes ____ No___ Acne Yes ____ No____
Herpes Simplex Yes ____ No____ Fungal Infections Yes ____ No____ Bacterial Infections Yes ____ No____

Metabolic Disorders:

Diabetes Yes ____ No____ Thyroid Disease Yes ____ No____ Liver Disease Yes ____ No____
Epilepsy Yes ____ No____ Kidney Disease Yes ____ No____ Cancer Yes ____ No____
Cancer Type? _____

Please indicate any other specific health problems you have. _____ Do you take any Prescription medications? Yes_____ No_____ If yes, please list the medications:_____
Are you allergic to any medications? Yes_____ No _____ If yes, please list medications: _____
Are you allergic to any chemicals, tape, latex, alcohol, cleaners, pollens or any other items? Yes_____ No _____ If yes, please list:_____

12. Have you visited our website and read the following:

Process: Yes ____ No____ 1st Steps: Yes ____ No____ FAQ's: Yes ____ No____ Before your Visit: Yes ____ No____

13. Do you have any questions for our doctor/staff? No Yes: _____