Integrated Body Contouring

☐ New Lenox phone: 815.717.8355 fax: 815.717.8416
☐ Joliet   phone: 815.439.2726 fax: 815.439.2741
☐ Roselle   phone: 224.655.6555 fax: 224.653.9395
☐ Naperville phone: 331-249-3999 fax: 331-249-4029

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: _____