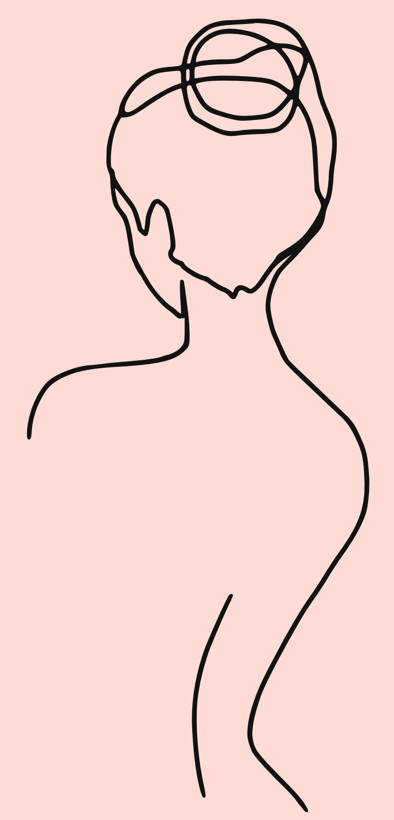
BODY SCULPTING

DIGITAL FORMS



CLIENT NAME:

BODY SCULPTING

CLIENT INTAKE FORM

CLIENT INFORMATION

Name: ______________________ Date: __________

Occupation: __________ Age: ______ ☐ Female ☐ Male ☐ NB

Address: ______________________

City: __________ State: ______ Zip: __________

Phone: __________ Email: ______________________

Emergency contact: ______________________ Phone #: __________

Would you like to be added to our email list for news and exclusive offers? *Yes* ☐ *No* ☐

MEDICAL HISTORY

Do you have or have you had any of the following conditions? *If yes, please select them*:

☐ Autoimmune disease	☐ Gallbladder removed	☐ Skin sensitivity
☐ Back/Neck pain	☐ High blood pressure	☐ Thrombosis/Phlebitis
☐ Cancer / Chemo	☐ History of gallstones	☐ Thyroid condition
☐ Cardiovascular condition	☐ Infections	☐ Tumors
☐ Diabetes	☐ Liver condition	☐ Metal bone pins/plates
☐ Epilepsy	☐ Skin diseases	☐ Phlebitis, blood clots

Any chronic medical conditions? ☐ No ☐ Yes: ______________________

Do you have hearing aids, pacemaker or hormone pellets (where) or metal/medical devices implanted?

☐ No ☐ Yes: ______________________

Do you have or have had cancer in the last 12 months? ☐ No ☐ Yes

If yes, are you currently on chemotherapy? ☐ No ☐ Yes

History of Colon problems including protruding/distended belly? ☐ No ☐ Yes: __________

Any known allergies? ☐ No ☐ Yes: ______________________

List any medications you take regularly: ______________________

Any recent surgery, including plastic surgery? ☐ No ☐ Yes, explain: __________

BODY SCULPTING
CLIENT INTAKE FORM

♀ When is your next menstrual cycle due to begin? ______________________

(Do not schedule Non-Surgical Lipo, Cavitation, or RF Skin Tightening treatments during your cycle. Your cycle will become heavy.)

Are you pregnant or trying to become pregnant? ☐ No ☐ Yes

Are you breastfeeding? ☐ No ☐ Yes

What is your primary area(s) of concern? ______________________

____

Do you want to loose body fat? ☐ No ☐ Yes

If yes, from what area(s)? ______________________

Do you want cellulite reduction? ☐ No ☐ Yes

If yes, from what area(s)? ______________________

Do you want to tighten skin on your body? ☐ No ☐ Yes

If yes, what area(s)? ______________________

Do you follow a current diet plan? ☐ No ☐ Yes

If yes, please explain? ______________________

Are you having regular exercise? ☐ No ☐ Yes

If yes, how often and what type? ______________________

Do you drink alcohol? ☐ No ☐ Yes

If yes: ☐ Once a month or less ☐ 2-4 times a month ☐ 2-3 times a week ☐ 4+ times a week

Do you drink water daily? ☐ No ☐ Yes

If yes, how much? ☐ 1-2 bottles ☐ 3-4 bottles ☐ 5-6 bottles ☐ 7+ bottles

By signing below, you agree to the following: I have completed this form truthfully and to the best of my knowledge. I agree to inform the technician of any changes in the above information. I agree to waive all liabilities toward my technician and the employer for any injury or damages incurred due to any misrepresentation.

______________________	______________________	__________
Client Name (printed)	*Client Name (signature)*	*Date*

BODY SCULPTING CONSENT FORM

Body sculpting increases flow of both the lymphatic and circulary systems, and it helps with cleaning of the tissues. Please be aware that this is not a weight loss treatment, but an inch loss. The main use of body sculpting treatments besides inch loss is diminishing of cellulite, and tightening of the skin. You can lose 1-3 inches per treatment but benefits may be delayed for some people. The inches will return if the client goes back to their old habits. Eating the right types of food, proper exercise, and drinking 8 glasses of water per day are always recommended. It is also recommended to avoid sugar and alcohol for 2 days after treatment.
For maximum results a series of 9-12 treatments is recommended. Some may require more treatments.

Precautions:
You are not allowed to do treatment if you are pregnant, breast feeding, have a lymphatic disorder, acute illness, metal implants, pacemakers, or are currently being treated for active cancer.

It is impossible to list every potential risk and complication. By signing this consent form you agree to have been informed of possible benefits, risks, and complications including but not limited to: redness, swelling, irritation, pain, increased heart rate, increased bowel movements, increased urination.

You also recognize there are no guaranteed results and that independent results are dependent upon age, skin condition, and lifestyle and that you may require further treatments of the treated areas to obtain the expected results at an additional cost.

The treatment is non-invasive and you should feel no discomfort. You need to notify your technician immediately if you feel any discomfort.

You are advised to speak to your doctor prior to making any decisions about altering any medical regimen you are currently following, changing your diet, taking supplements, or going on an exercise and/or weight loss program. Getting your doctor's approval prior to starting any treatment is solely your responsibility.

_______________________ _______________________ ___________

Client Name (printed) *Client Name (signature)* *Date*

_______________________________ ___________

Technician (signature) *Date*

BODY SCULPTING CONSENT FORM

______ I understand there are no guarantees as to the results of this treatment.

______ I understand that to achieve maximum results a series of 9-12 body sculpting treatments are recommended per area.

______ I understand that I should consume a healthy diet and exercise regularly to achieve optimal results.

______ I understand that if I feel any sort of discomfort during treatment I will notify my technician immediately who will then stop the treatment.

______ I have been informed and understand that if I choose to continue treatment with discomfort it is at my own risk and I will release technician of all responsibility.

______ I do not have any of these conditions: lymphatic disorder, cardiac issues, acute illness, metal implants, pacemakers, or are currently being treated for active cancer.

______ I am not pregnant nor am I breast feeding.

______ I have been informed of potential risks and side effects including but not limited to: redness, swelling, irritation, pain, increased heart rate, increased bowel movements, increased urination.

______ I have had the opportunity to ask questions about risks and complications.

______ I understand that photographs and measurements will need to be taken in order to review and record results and will be kept in client file.

______ I certify that I am over the age of 18.

By signing below, you agree to the following:
I am over 18 years of age and consent to this agreement and to treatment. I have completed these forms truthfully and to the best of my knowledge. I acknowledge that I have been given full opportunity to ask any and all questions which I might have about the hairstyling procedure, and that all my questions have been answered to my full satisfaction, I specifically acknowledge I have been advised of the facts and matters set forth.

____________________ ____________________ __________

Client Name (printed) *Client Name (signature)* *Date*

____________________ __________

Technician (signature) *Date*

BODY SCULPTING
MEASUREMENT TRACKING & TREATMENT CHART

PERSONAL INFORMATION

Name: ______________________ Date: __________

Date of birth: ______________ Age: ________ Height : __________

Sessions purchased: ________ Treatment area: ______________________

Price: ______________ Payment plan: ______________________

Amount owed: __________ Payment type: ________ Final payment date: ________

Notes: ____

	Chest	Waist	Hips	Weight	BMI	BF%	VF
VISIT 1 Date: ___ / ___ / ___							
VISIT 2 Date: ___ / ___ / ___							
VISIT 3 Date: ___ / ___ / ___							
VISIT 4 Date: ___ / ___ / ___							
VISIT 5 Date: ___ / ___ / ___							
VISIT 6 Date: ___ / ___ / ___							

BODY SCULPTING

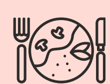
MEASUREMENT TRACKING & TREATMENT CHART

	Chest	Waist	Hips	Weight	BMI	BF%	VF
VISIT 7 Date: ___ / ___ / ___							
VISIT 8 Date: ___ / ___ / ___							
VISIT 9 Date: ___ / ___ / ___							
VISIT 10 Date: ___ / ___ / ___							
VISIT 11 Date: ___ / ___ / ___							
VISIT 12 Date: ___ / ___ / ___							
VISIT 13 Date: ___ / ___ / ___							
VISIT 14 Date: ___ / ___ / ___							
VISIT 15 Date: ___ / ___ / ___							
VISIT 16 Date: ___ / ___ / ___							

BODY SCULPTING

PRE-TREATMENT

PRE-TREATMENT ADVICE



Drink at least 2 l of water the day before treatment.

Avoid caffeine, alcohol and carbonated drinks 24 h before treatment.

Avoid heavy meals the day before & do not eat 2 hours before your treatment.

Shave any body hair on and around the area to be treated.

Remove any lotion and cream from your skin before treatment.

Wear loose fitting clothes on the day of treatment.

Internal Beauties
Body Contouring & Wellness

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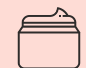

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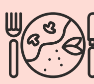
Internal Beauties
Body Contouring & Wellness



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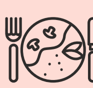

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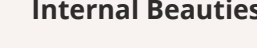

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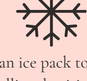
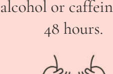
Internal Beauties
Body Contouring & Wellness

BODY SCULPTING

AFTERCARE ADVICE

Body Sculpting AFTERCARE ADVICE

- Drink plenty of water and stay hydrated.
- Do not drink any alcohol or caffeine for 48 hours.
- Avoid sauna, spa, hot tubs, hot shower & for 24 hours.
- Use an ice pack to reduce swelling, bruising and stiffness.
- Engage in 30 min light exercise, like walking, within 6 hours to stimulate lymphatic drainage.
- Massage the treated area daily to prevent toxins from becoming stagnant.
- Maintain a healthy diet and regular exercise to preserve the result.
- Don't forget to book your next appointment.

Internal Beauties
Body Contouring & Wellness

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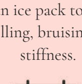
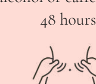

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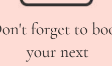

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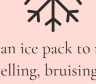

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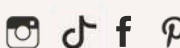

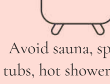
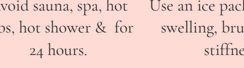

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