BEYOND BEAUTY Academy MEDICAL AESTHETICS

Body Contouring INTAKE

PERSONAL INFORMATION

Name: _____ Date: _____

Date of birth: _____ Age: _____ ☐ Female ☐ Male

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Emergency contact: _____ Phone: _____

How did you hear about us? _____

Would you like to be added to our email list for news and exclusive offers? ☐ Yes

HEALTH HISTORY

Please check any of the following conditions that applies to you:

- ☐ Acne
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood disorder
- ☐ Cancer
- ☐ Diabetes
- ☐ Eczema
- ☐ Epilepsy
- ☐ Fever blisters
- ☐ Heart condition
- ☐ Herpes
- ☐ Hepatitis A/B/C
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ Hyper pigmentation
- ☐ Hormone Imbalance
- ☐ Hysterectomy
- ☐ Immune disorders
- ☐ Insomnia
- ☐ Keloid scarring
- ☐ Low blood pressure
- ☐ Lupus
- ☐ Metal bone pins/plates
- ☐ Spinal Injury
- ☐ Seizure disorder
- ☐ Skin Disease Disorder
- ☐ Seborrhea
- ☐ Thyroid condition
- ☐ Veins/Phlebitis
- ☐ Warts

Any other conditions: _____

Do you have any medication allergies? ☐ No ☐ Yes _____

Are you currently taking any medication (including vitamins and supplements)? List it here:

_____

Any surgeries in the last six months? ☐ No ☐ Yes _____

Are you pregnant or breastfeeding? ☐ No ☐ Yes _____

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

BODY CONTOURING CONSULTATION FORM - CONT'D

ADDITIONAL INFORMATION

1) What concerns would you like to address today?

_____

2) What skin problems do you think you have?

_____

3) Do you want to lose body fat? ☐ No ☐ Yes (specify the area) _____

4) Do you want to tighten skin on your body? ☐ No ☐ Yes (specify the area) _____

5) Do you want to reduce cellulite? ☐ No ☐ Yes (specify the area) _____

☐ No ☐ Yes (specify the area) _____

6) Please list your regular exercise habits:

_____

7) Please describe your current dietary habits:

_____

8) How many ounces of water do you drink daily? _____

Any other information you'd like to provide:

_____

By signing below, I agree to the following:

I have completed this form to the best of my ability and knowledge. I agree to inform the technician of any changes in the above information. I agree that I do not have any condition(s) that would make the requested treatment unsuitable. I will inform the technician of any discomfort I may experience at any time during my treatment to allow them to adjust accordingly. I agree to waive all liability toward my technician and the salon for any injury or damages incurred due to any misrepresentation of my health.

PATIENT NAME (PRINTED)	
PATIENT SIGNATURE	
DATE	
MEDICAL PROVIDER	