

**CLIENT PROFILE**

Surname: \_\_\_\_\_ First Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Mobile: \_\_\_\_\_ Home Tel: \_\_\_\_\_ Work Tel: \_\_\_\_\_

Email: \_\_\_\_\_ Profession: \_\_\_\_\_

How did you hear about us? Please Circle The Star, Walk By, Friend, Internet, Staff Member at clinic

Other Please State: \_\_\_\_\_

MAIN TARGET AREAS: \_\_\_\_\_

**DAILY LIFE:**

Number of cigarettes per day? \_\_\_\_\_ How long have you been smoking? \_\_\_\_\_

Have you every smokd in the past? If so how long and how many? \_\_\_\_\_

Cups of coffee per day? \_\_\_\_\_ Cups of tea per day? \_\_\_\_\_

Water Intake: \_\_\_\_\_ litres per day: \_\_\_\_\_ Alcohol intake/per week \_\_\_\_\_

Balanced nutrition: Yes<sup>1</sup> No<sup>1</sup> Physical activities: Yes<sup>1</sup> No<sup>1</sup>

Pls Explain: \_\_\_\_\_ Psychological stress: Yes<sup>1</sup> No<sup>1</sup>

**FEMALE DATA:**

Are you pregnant? Yes<sup>1</sup> No<sup>1</sup> Menopause Yes<sup>1</sup> No<sup>1</sup>

Contraception: Yes<sup>1</sup> No<sup>1</sup> Hormonal Substitutive Treatment \_\_\_\_\_

Currently Breastfeeding Yes<sup>1</sup> No<sup>1</sup> Date menstrual cycle commences \_\_\_\_\_

No of children \_\_\_\_\_ No. of ceserian births \_\_\_\_\_

**HEALTH:**

Are you currently receiving any medical treatment: \_\_\_\_\_ Yes<sup>1</sup> No<sup>1</sup>

If yes, what type? \_\_\_\_\_

Are you on any medication? If yes, what type? \_\_\_\_\_

Are you on any anti coagulant treatments or blood thinners? Yes<sup>1</sup> No<sup>1</sup>

In the last 12 months have you suffered from any of the following?

<i>Lipoma</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<i>HIV</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<i>High Blood Pressure</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<i>Hepatitis</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<i>Phlebitis (Deep Vein Thrombosis)</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<i>Hernia</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<i>Varicose veins</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<i>Skin rash</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<i>Cancer</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<i>Heart Attack</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<i>Constipation</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<i>STD'S</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

What do you want to achieve by having this treatment? \_\_\_\_\_

Please state your main motivations with your body? \_\_\_\_\_

What would it mean to you if you could achieve your results? \_\_\_\_\_

How important is this to you? On a scale of 1 being not important to **10 being very important**

How high do you regard your health & wellbeing from 1-10?

How committed are you to achieving your goal from 1-10?

How long has this concern been on your mind? \_\_\_\_\_

What is a favourite item of clothing you haven't worn that you would like to wear again? \_\_\_\_\_

What has stopped you in the past from achieving your goal? \_\_\_\_\_

How would you feel if you reached you goal? \_\_\_\_\_

Have you had any plastic or cosmetic surgery in the last 10 years? \_\_\_\_\_

**EMERGENCY CONTACTS** Name: \_\_\_\_\_ No: \_\_\_\_\_

Customer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please tick the box if you do not wish to receive specials and/or promotional material.**