

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: Yes¹ No¹ Physical activities: Yes¹ No¹

Pls Explain: _____ Psychological stress: Yes¹ No¹

FEMALE DATA:

Are you pregnant? Yes¹ No¹ Menopause Yes¹ No¹

Contraception: Yes¹ No¹ Hormonal Substitutive Treatment _____

Currently Breastfeeding Yes¹ No¹ Date menstrual cycle commences _____

No of children _____ No. of ceserian births _____

HEALTH:

Are you currently receiving any medical treatment: _____ Yes¹ No¹

If yes, what type? _____

Are you on any medication? If yes, what type? _____

Are you on any anti coagulant treatments or blood thinners? Yes¹ No¹

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

<i>Lipoma</i>	Yes ¹	No ¹	<i>HIV</i>	Yes ¹	No ¹
<i>High Blood Pressure</i>	Yes ¹	No ¹	<i>Hepatitis</i>	Yes ¹	No ¹
<i>Phlebitis (Deep Vein Thrombosis)</i>	Yes ¹	No ¹	<i>Hernia</i>	Yes ¹	No ¹
<i>Varicose veins</i>	Yes ¹	No ¹	<i>Skin rash</i>	Yes ¹	No ¹
<i>Cancer</i>	Yes ¹	No ¹	<i>Heart Attack</i>	Yes ¹	No ¹
<i>Constipation</i>	Yes ¹	No ¹	<i>STD'S</i>	Yes ¹	No ¹

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.