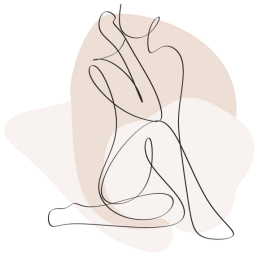
Flawless
Body & Lash Studio

CONSULTATION FORM



PERSONAL INFORMATION

Name: _____ Date: _____

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

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** ☐ **No** ☐

MEDICAL HISTORY

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

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

♀ 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 of my health history.

Client Name (printed) :

Client Name (signature) : Date:

Technician: Date: