Body Treatment Record Card

STRICTLY PROFESSIONAL

Name _____ Date of Birth _____ Tel: (Home) _____

Address _____ Tel: (Work) _____

_____ Mobile _____

Dr Name _____ Practice _____ Tel _____ Email _____

Present Medical Treatment _____ Medication/Supplements _____

_____

Allergies _____ Liquids Consumed Today _____

Client Main Concerns and Expectations _____ Previous Body Treatments _____

_____ _____

General Questions

- ☐ Diabetes
- ☐ Circulatory Conditions
- ☐ High/Low Blood Pressure
- ☐ Epilepsy
- ☐ Thrombosis
- ☐ Back/Joint Problems
- ☐ Psoriasis/Eczema
- ☐ Recent Scars
- ☐ Claustrophobia
- ☐ Panic Attacks
- ☐ Recent Waxing, Laser or IPL
- ☐ HRT
- ☐ Pregnant
- ☐ Menstruation
- ☐ Breast Feeding
- ☐ Kidney/Liver Disorders
- ☐ Headache/Migraine
- ☐ Time Since Eaten

Diet

- ☐ Smoke
- ☐ Tea
- ☐ Coffee
- ☐ Water
- ☐ Alcohol
- ☐ Juice

Body Frame

Height _____

Weight _____

Lifestyle

- ☐ Active
- ☐ Sedentary

Occupation _____

Exercise

Times per week _____

Type of Exercise _____

_____

Areas and types of cellulite _____

Analysis of muscle tone _____

Indemnity/Consent

- ☐ I confirm that I understand the treatment and the answers I have given are true and correct.
- ☐ I give my consent for the treatment to take place.

Client Signature _____ Date _____ Client Signature _____ Date _____

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Information is confidential and is only used by staff for your treatments. Details will not be passed to a third party.

Therapist Signature _____ Date of Consultation _____