Body - Customer Consultation Form

Name:

Address:

Birthday: _____/_____/_____

Telephone:

Cell Phone:

Fax Number:

E-mail:

Referred by:

Please note: This form must be filled in and signed by the Customer wishing to begin a course of treatment. All treatments will be performed by fully trained operators using the recommended skin care products.

All the questions are answered truthfully by me and I understand that some conditions may be contra indications to receiving treatment. _____ will therefore not accept any liability for injury or damages as a result of false information given.

Customer Name	**Date**
Therapist Name:	**On behalf of:**

1. Do you have any serious illness? YES NO
DETAILS:_____

2. Have you had any recent operations with general anesthetic? YES NO
DETAILS:_____

3. Do you have a pacemaker? YES NO
DETAILS:_____

4. Are you under any physical or psychological treatment? YES NO
DETAILS:_____

5. Do you have any hormone imbalance that you know of? YES NO
DETAILS:_____

6. Do you suffer from varicose veins? YES NO
DETAILS:_____

7. Do you suffer from a thyroid condition? YES NO
DETAILS:_____

8. Are you pregnant or trying to get pregnant? YES NO
DETAILS:_____

9. Are you epileptic or suffer from fits? YES NO
DETAILS:_____

10. Do you have any metal implants? YES NO
DETAILS:_____

11. Have you suffered from any skin conditions? YES NO
DETAILS:_____

12. Do you suffer from water retention? YES NO
DETAILS:_____

13. Do you follow a regular exercise routine? YES NO
HOW OFTEN?:_____

14. Do you eat fast foods? (ex. KFC, McDonalds, etc.) YES NO
HOW OFTEN?:_____

15. Do you smoke? YES NO
How many per day?:_____

16. Have you ever had a tummy tuck or liposuction? YES NO
DETAILS:_____

17. Do you have swollen feet? YES NO
DETAILS:_____

18. What do you drink Coffee/Tea/Alcohol? YES NO
_____cups coffee/tea per day. _____unit of alcohol per week

19. How many glasses of WATER do you drink per day?
_____cups per day

20. Are you taking any medication? YES NO
DETAILS:_____

21. Do you include salads and fruits in your diet? YES NO
HOW OFTEN?:_____

22. Do you have a lot of carbohydrates, fats, or meats? YES NO
DETAILS:_____

23. Do you include Iodine or Kelp in your diet? YES NO
HOW OFTEN?:_____

24. Have you ever had an adverse reaction to electrical treatment before? YES NO
DETAILS:_____