

Body Contouring Questionnaire

Today's Date _____ Birthday _____

Name _____

Address _____

City _____ State _____ Zip _____

Cell Phone (____) _____ Email _____

How did you hear about us? _____

What is your occupation? _____

Do you have any children? ___ yes ___ no If yes, how many? _____ Age range? _____

Have you ever had a body treatment? ___ yes ___ no

If yes, when/what kind? _____

Do you have any current medical conditions? ___ yes ___ no

If yes, please list

Are you taking any prescription medications, either topical or internal? ___ yes ___ no

If yes, what? _____

Do you smoke? ___ yes ___ no If yes, how much per day? _____

Have you had any cosmetic surgery? ___ yes ___ no

If yes, what and when? _____

Describe your current daily routine.

Do you sit or stand for long periods of time? ___ yes ___ no How long? _____

Nutritional Habits _____

Water Intake _____ Elimination _____

Exercise _____ Other _____

What are your goals for your body? _____

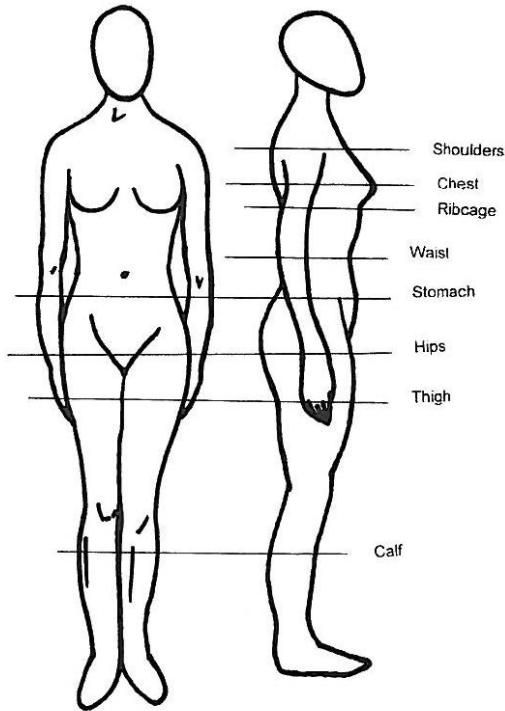
(Write them down, repeat them back, and ask for clarification of goals so you understand what they mean)

Did I get that correct? _____ Is there anything I missed? _____

Consultation Summary

Body Contour Chart

Measure on 1st & 6th treatments.



	First Treatment	Sixth Treatment
Date	_____	_____
Shoulders	_____	_____
Chest	_____	_____
Ribcage	_____	_____
Waist	_____	_____
Stomach	_____	_____
Hips	_____	_____
Thigh	_____	_____
Calf	_____	_____

How does your body feel? _____

Do you have any questions about your treatment? _____

Based on your goals I am going to recommend that you take these products home and I see you every _____ weeks. (pause!) How does that sound? (sssshhhh)

Initial product recommendation? _____

Initial product purchase. _____

Date	Treatment	Rebook Date	Product Sales
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Technician: _____