BODY SCULPT

Customer Name:

Email Address:

Address:

Contact Number:

Procedure(s):

Confidential Medical History Questionnaire

Answer YES or NO to the following questions; if YES , give more details overleaf. If you do not understand any of the question please ask a member of staff.

Question	Yes	No
Do you have a history of Cancer and undergone radiotherapy or chemotherapy in the past 5 years?	◯ Yes	◯ No
Are you taking or have taken steroids/cortisone in the past 12 months?	◯ Yes	◯ No
Are you allergic to any materials or products used?	◯ Yes	◯ No
Do you have a pacemaker or suffered heart conditions in the past?	◯ Yes	◯ No
Are you suffering from any form of liver or kidney disease?	◯ Yes	◯ No
Are you suffering from or had fibrosis, Hepatitis all forms?	◯ Yes	◯ No
Are you recovering from an operation within the last 6 weeks?	◯ Yes	◯ No
Are you diagnosed with any longterm medical conditions?	◯ Yes	◯ No
Are you suffering from osteoarthritis?	◯ Yes	◯ No
Are you pregnant or breast feeding?	◯ Yes	◯ No
Have you had acne treatment Ro-accutane within the past 6 months?	◯ Yes	◯ No
Are you Diabetic?	◯ Yes	◯ No
Do you have kidney disease?	◯ Yes	◯ No
Do you suffer from thyroid disorders?	◯ Yes	◯ No
Do you suffer from Epilepsy?	◯ Yes	◯ No
Are you on any blood thinning medication?	◯ Yes	◯ No
Do you have any active blood clots?	◯ Yes	◯ No

THE BODY OF KENT

EST. 2024

Treatment Restrictions

(This may limit or restrict the treatment)

Question		
Do you suffer from any skin conditions or diseases? (Eczema, Psoriasis etc)	◯ Yes	◯ No
Do you suffer from any other allergies?	◯ Yes	◯ No
Do you suffer with blackouts, fainting or dizziness?	◯ Yes	◯ No
Do you have any silica implants?	◯ Yes	◯ No
Do you have high blood pressue?	◯ Yes	◯ No
Do you have any metal plates or pins in your body?	◯ Yes	◯ No
Do you have any contraceptive coil specifically copper - non hormonal?	◯ Yes	◯ No

Please give details if any boxes are ticked "Yes"

Additional Notes:

Client signature:

Therapist signature:

Date: