New Client History

Name: _____ Date: _____
Address: _____
City: _____ State: _____ Zip: _____
Birth Date:___/___/___ Sex: _____
Cell Phone: _____ Home Phone:_____
Work Phone:_____
Email Address:_____ Occupation: _____
How did you hear about us? _____

What is your main area(s) of focus/your problem area(s)?

_____

Medical History

1. Do you have any chronic medical conditions which we should know about? Yes or No.

   If so, please list them: _____

2. Do you have any allergies to latex, medications, herbal or natural supplements?
   Yes ( ) No ( )

   If so, please list them: _____

3. Do you have any allergies to latex, medications, herbal or natural supplements?
   Yes ( ) No ( )

If so, please list them: _____

4. Do you have, or have you had, any changes in medical history recently?
   Yes ( ) No ( )

   If so, please list them: _____

5. Do you have, or have you had, any changes in medical history recently?
   Yes ( ) No ( )

   If so, please list them: _____

6. Do you have, or have you had, any changes in medical history recently?
   Yes ( ) No ( )

   Explain: _____

7. Do you have Hearing aids, Pacemaker or Hormone Pellets (where), or metal/medical devices implanted? Yes ( ) No ( )

   Explain:_____

8. Do you have type 1 or 2 Diabetes? Yes ( ) No ( )

   Please list all current medications including Vitamins:
   _____
   _____
   _____

9. Do you have or have you had Cancer in the last 12 months?
   Yes ( ) No ( )

   If yes, are you currently on chemotherapy? Yes ( ) No ( )

10. Do you have a Thyroid Problem? Yes ( ) No ( )

11. Do you have High Blood Pressure or Cardiovascular conditions?
    Yes ( ) No ( )

12. Women Only, are you currently pregnant or nursing?
    Yes ( ) No ( )

13. Please give us your current Weight _____ and Height _____.

14. What is your Ethnic Background? _____.

Circle which applies to you:

Epilepsy	Yes ( ) No ( )
Loss of Normal Skin Sensation	Yes ( ) No ( )
Neck/Back Problems	Yes ( ) No ( )
Gallbladder Removed	Yes ( ) No ( )
History of Gallstones	Yes ( ) No ( )
History of Liver Problems	Yes ( ) No ( )

Are you currently dieting?
Yes ( ) No ( )

Explain: _____

History of Colon

Problems including protruding/distended belly?
Yes ( ) No ( )

Explain:_____

Have you had any surgeries?
Yes ( ) No ( )

Infections Tumors Thrombosis/Phlebitis
Yes ( ) No ( )

Skin Diseases Autoimmune Disease
Yes ( ) No ( )

Typical Daily foods and drink intake

1. How many glasses of water do you usually drink? _____
2. How many cups of coffee do you usually drink? _____
3. How much alcohol do you usually drink? _____
4. How often do you eat fast food? _____
5. How much carbonation (ea. Soft drinks) do you usually take? _____

Do you use tobacco? Yes ( ) No ( )
Recreational Drugs (narcotics)? Yes ( ) No ( )

How is your stress level?
Moderate ( )
Average ( )
Demanding ( )

I (print your name) _____ consent to allow Ambiance Spa and Wellness LLC's staff members to consult with & evaluate me in order to determine if I am a good candidate for the Non-surgical Body Contouring Program. I understand that photographs and measurements will be taken and kept in my file.

I agree that these forms have been completed truthfully and to the best of my knowledge/abilities.

Signature: _____

(if minor, parent's signature)

Date: _____