

Body Wisdom Client Consultation Card

To assist in tailoring your treatment to treat your specific needs we will require some information about you. Please fill in as many of the questions as you can as honestly as possible. This client card is for your therapists use only and all information will be kept confidential.

Title: Miss Mrs Ms Mr Name: _____
Address: _____ Postcode: _____
Home Phone: _____ Work Phone: _____ Mobile Phone: _____
Email: _____ Occupation: _____ DOB: _____
How did you hear about us? _____
Would you like to receive information about or current promotions? Yes No

Are you interested in any of the following treatments?

Endermologie/Cellulite treatments Detox/Wellbeing programs Beauty treatments
IPL/permanent hair reduction Body products Skincare products

Medical Information (Please tick)

High/Low Blood Pressure	<input type="checkbox"/>	Allergies	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Anaphylactic reaction	<input type="checkbox"/>
Metal pins/implants	<input type="checkbox"/>	Sports/Vehicle Accident	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	Spinal problems	<input type="checkbox"/>
Thyroid condition	<input type="checkbox"/>	Heart conditions/pacemaker	<input type="checkbox"/>
Varicose veins	<input type="checkbox"/>	Cancer	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	Current bruising/swelling	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Bowel conditions	<input type="checkbox"/>
Skin irritation	<input type="checkbox"/>	Surgery in the last 5 years	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	Plastic/cosmetic surgery	<input type="checkbox"/>
HIV	<input type="checkbox"/>	Hormonal imbalance	<input type="checkbox"/>
Recent sun/solarium exposure	<input type="checkbox"/>	Claustrophobia	<input type="checkbox"/>
Contact lenses	<input type="checkbox"/>	Other medical conditions	<input type="checkbox"/>

Details: _____

General Health Information

Do you smoke: Yes No Do you follow a restricted diet: Yes No
How often do you exercise: 3+ times a week 1 – 3 a week Less
Weekly consumption of the following: Alcohol _____ Tea/coffee _____ Water _____
Current stress level: Low Medium High
Current sleep pattern: Deep Regular Broken Insomnia
Are you currently pregnant: Yes No Are you currently breastfeeding: Yes No
Do you take any supplements: Yes No Do you take any medication: Yes No
Details: _____

Please turn over