INTAKE FORM

Your success is our #1 priority.

Help us to help you achieve that success by filling out this questionnaire as completely as possible.

SHAPING YOUR BODY, MIND, SPIRIT

Name:____Date:___________

Address:____

Home #:______________________________ Work #:________________________

Cell #:________________________________Email:_________________________

Height:_______Weight:_______ Age:______ Gender_______Birthdate:__________

How did you learn about us?____

If a friend Referred you please include a name for our referral program.

____

Do you have a special occasion or completion date.________________________

Does you Family support you?_________________________

Do you feel stress (explain)?__________________________

Are you currently under the care of a physician?______________________

If yes Why?____

Surgery History____

Medications____

____

Current level of exercise: Light________ Moderate__________ Heavy______________

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What areas would you like to target with your your Fascia Blasting &/ or Body Sculpting treatment?

____

____

Significant Health Conditions:

____

____

____

Medications Being Taken:

____

____

Please indicate any of the following conditions that you currently have

- ☐ headaches
- ☐ cancer
- ☐ heart/circulation problems
- ☐ major accident
- ☐ neck / back injuries
- ☐ numbness
- ☐ allergies
- ☐ TMJ
- ☐ joint surgery
- ☐ varicose veins
- ☐ diabetes
- ☐ sprains, strains
- ☐ arthritis, tendonitis
- ☐ abnormal skin condition
- ☐ high / low blood pressure
- ☐ blood clots
- ☐ fibromyalgia
- ☐ recent injuries

Explain Any Conditions You Have Marked Above:

____

____

____

Signature: ____________________________________ **Date:** __________

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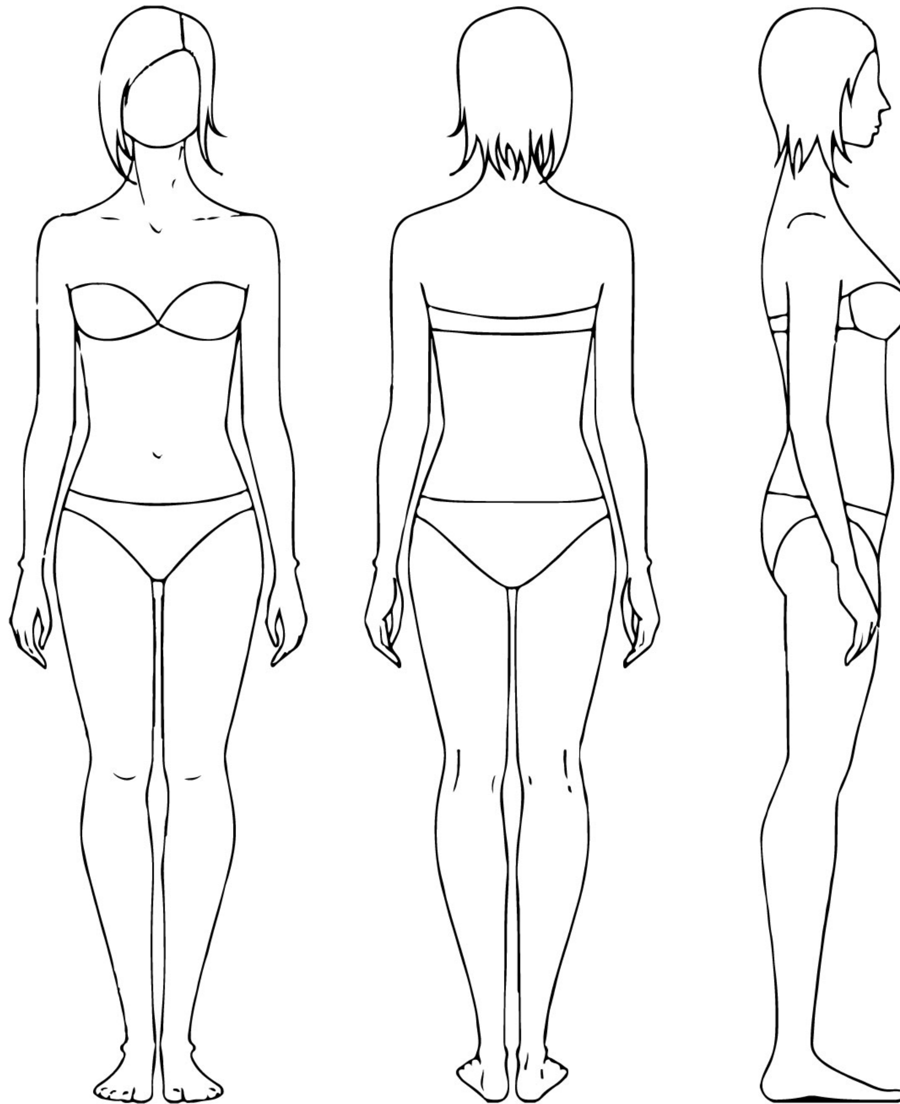
Please circle the 3 or 5 areas you would like to target.



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