

Results Weight Loss and Med Spa

Client Health Profile

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Home: _____ Work: _____

Email: _____

Referred By: _____ Birthdate: _____

Height: _____ Weight: _____ Female Male Married Single

Emergency Contact: _____ Phone: _____

Occupation: _____ Full Time or Part Time

List all your allergies: _____

List all prescription medications: _____

List all supplements: _____

1) Have you had any of these health conditions in the past or present? Check all that apply.

Cancer	<input type="checkbox"/>	Headaches (chronic)	<input type="checkbox"/>
Hormone imbalance	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>
Systemic disease	<input type="checkbox"/>	Herpes	<input type="checkbox"/>
High/Low blood pressure	<input type="checkbox"/>	Frequent cold sores	<input type="checkbox"/>
Spinal injury	<input type="checkbox"/>	Autoimmune disorders	<input type="checkbox"/>
Thyroid condition	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>
Hysterectomy	<input type="checkbox"/>	Lupus	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Metal bone pins or plates	<input type="checkbox"/>
Heart problems	<input type="checkbox"/>	Phlebitis, blood clots, poor circulation	<input type="checkbox"/>
Varicose veins	<input type="checkbox"/>	Blood clotting abnormalities	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	Light sensitivities	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Wear contacts or glasses	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	Form thick or raised scars from injuries	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	Skin disease/lesions	<input type="checkbox"/>
Seizure disorder	<input type="checkbox"/>	Any active infection	<input type="checkbox"/>
Sinus problems	<input type="checkbox"/>	Connective tissue disease	<input type="checkbox"/>
Wear a pacemaker	<input type="checkbox"/>	Experienced claustrophobia	<input type="checkbox"/>
Liver conditions	<input type="checkbox"/>	Any other health conditions? _____	<input type="checkbox"/>

Explain any checked or other health conditions: _____

2) Answer the following yes or no questions:

Are you pregnant or nursing? Y N Taking oral contraceptives? Y N
 Do you have a heart condition? Y N Describe: _____
 Are you under the care of a physician or dermatologist for an ongoing condition? Y N
 Describe: _____
 List any recent surgeries/plastic surgery? _____

Do you smoke? Y N Do you drink alcohol? Y N Weekly consumption? _____
 Do you exercise regularly? Y N Daily consumption of: Water _____ Caffeine _____
 Do you follow a restricted diet? Y N Describe: _____
 Problems sleeping? Y N How many hours a night? _____
 What is your level of stress? High Medium Low

