
# Body Contouring CONSULTATION

## PERSONAL INFORMATION

**FIRST NAME**

**LAST NAME**

**DATE OF BIRTH**

**GENDER**

MALE ○ FEMALE ○ NONE ○

**AGE**

**HEIGHT**

## CONTACT DETAILS

**EMAIL ADDRESS**

**PHONE NUMBER**

**HOME ADDRESS**

**CITY, STATE**

**ZIP CODE**

HOW MAY WE CONTACT YOU? PHONE ○ EMAIL ○ POST ○

**EMERGENCY CONTACT NAME & PHONE**

**HOW DID YOU HEAR ABOUT US?**

(If someone referred you, please name them so that we may thank them)

**Friend Referral**_____

**Social Media**

(Please indicate which version you used to find out about our services)

Facebook ○ Instagram ○ Website ○ Other ○ (please specify below)

BEAUTYCARE

# Body Contouring

# MEDICAL

Do you have any chronic medical conditions which we should know about?
Yes ○ No ○ If so, please list: _____

Do you have allergies, to latex, medications, herbal or natural supplements?
Yes ○ No ○ If so, please list: _____

Do you have, or have you had, any changes in medical history recently?
Yes ○ No ○ If so, please explain:
_____

Do you have Hearing aids, Pacemaker or Hormone Pellets (where) or metal/medical devices implanted Yes ○ No ○ If so, please explain:
_____

Do you have type 1 or 2 Diabetes? Yes ○ NO ○
List all current Medications including
Vitamins:_____

Do you have or have you had Cancer in the last 12 months? Yes. ○ No ○
If yes, are you currently on chemotherapy? Yes. ○ No ○
Do you have a Thyroid Problem? Yes. ○ No ○
Do you have High Blood Pressure or a Cardiovascular conditions? Yes. ○ No ○

Have you ever had a medical aesthetics procedure to improve your appearance?
Yes ○ No. ○ If so, please list: _____

FEMALES ONLY
Are you currently (or possibly may be) pregnant? Yes. ○ No ○
Have you given birth within the last 6 months? Yes. ○ No ○
Have you breastfed within the last 6 months? Yes ○ No ○

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# Body Contouring
# MEDICAL HISTORY

Tick any which applies to you:

- Epilepsy
- Infections
- Tumors
- Skin Diseases
- Loss of Normal Skin Sensation
- Thrombosis/Phlebitis
- Autoimmune Disease

Please explain: _____

| | | |
|---|---|---|
| History of Gallstones | Yes. | No |
| History of Liver Problems | Yes. | No |
| History of Colon problems including protruding/distended belly? | Yes. | No |
| Have you had any recent surgeries? | Yes. | No |

**WHAT ARE YOUR MAIN AREA(S) OF FOCUS/YOUR PROBLEM AREA(S)**

I, (print name) , consent to allow the 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.

**Client Name: _____Date_____**

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# Body Contouring

# BODY MASS INDEX

## BMI & BODY CHARTING

### PLEASE USE THE CHART TO CALCULATE YOUR BODY MASS INDEX

| WEIGHT lbs | 100 | 105 | 110 | 115 | 120 | 125 | 130 | 135 | 140 | 145 | 150 | 155 | 160 | 165 | 170 | 175 | 180 | 185 | 190 | 195 | 200 | 205 | 210 | 215 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| kgs | 45.5 | 47.7 | 50.0 | 52.3 | 54.5 | 56.8 | 59.1 | 61.4 | 63.6 | 65.9 | 68.2 | 70.5 | 72.7 | 75.0 | 77.3 | 79.5 | 81.8 | 84.1 | 86.4 | 88.6 | 90.9 | 93.2 | 95.5 | 97.7 |
| HEIGHT in/cm | Underweight | | | | | | Healthy | | | | | Overweight | | | | | Obese | | | | | Extremely obese | | |
| 5'0" 152.4 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 | 41 | 42 |
| 5'1" 154.9 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 36 | 37 | 38 | 39 | 40 |
| 5'2" 157.4 | 18 | 19 | 20 | 21 | 22 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 36 | 37 | 38 | 39 |
| 5'3" 160.0 | 17 | 18 | 19 | 20 | 21 | 22 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 36 | 37 | 38 |
| 5'4" 162.5 | 17 | 18 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 36 | 37 |
| 5'5" 165.1 | 16 | 17 | 18 | 19 | 20 | 20 | 21 | 22 | 23 | 24 | 25 | 25 | 26 | 27 | 28 | 29 | 30 | 30 | 31 | 32 | 33 | 34 | 35 | 35 |
| 5'6" 167.6 | 16 | 17 | 17 | 18 | 19 | 20 | 21 | 21 | 22 | 23 | 24 | 25 | 25 | 26 | 27 | 28 | 29 | 29 | 30 | 31 | 32 | 33 | 34 | 34 |
| 5'7" 170.1 | 15 | 16 | 17 | 18 | 18 | 19 | 20 | 21 | 22 | 22 | 23 | 24 | 25 | 25 | 26 | 27 | 28 | 29 | 29 | 30 | 31 | 32 | 33 | 33 |
| 5'8" 172.7 | 15 | 16 | 16 | 17 | 18 | 19 | 19 | 20 | 21 | 22 | 22 | 23 | 24 | 25 | 25 | 26 | 27 | 28 | 28 | 29 | 30 | 31 | 32 | 32 |
| 5'9" 175.2 | 14 | 15 | 16 | 16 | 17 | 18 | 19 | 20 | 20 | 21 | 22 | 22 | 23 | 24 | 25 | 25 | 26 | 27 | 28 | 28 | 29 | 30 | 31 | 32 |
| 5'10" 177.8 | 14 | 15 | 15 | 16 | 17 | 18 | 18 | 19 | 20 | 20 | 21 | 22 | 23 | 23 | 24 | 25 | 25 | 26 | 27 | 28 | 28 | 29 | 30 | 30 |
| 5'11" 180.3 | 14 | 14 | 15 | 16 | 16 | 17 | 18 | 18 | 19 | 20 | 21 | 21 | 22 | 23 | 23 | 24 | 25 | 25 | 26 | 27 | 28 | 28 | 29 | 30 |
| 6'0" 182.8 | 13 | 14 | 14 | 15 | 16 | 17 | 17 | 18 | 19 | 19 | 20 | 21 | 21 | 22 | 23 | 23 | 24 | 25 | 25 | 26 | 27 | 27 | 28 | 29 |
| 6'1" 185.4 | 13 | 13 | 14 | 15 | 15 | 16 | 17 | 17 | 18 | 19 | 19 | 20 | 21 | 21 | 22 | 23 | 23 | 24 | 25 | 25 | 26 | 27 | 27 | 28 |
| 6'2" 187.9 | 12 | 13 | 14 | 14 | 15 | 16 | 16 | 17 | 18 | 18 | 19 | 19 | 20 | 21 | 21 | 22 | 23 | 23 | 24 | 25 | 25 | 26 | 27 | 27 |
| 6'3" 190.5 | 12 | 13 | 13 | 14 | 15 | 15 | 16 | 16 | 17 | 18 | 18 | 19 | 20 | 20 | 21 | 21 | 22 | 23 | 23 | 24 | 25 | 25 | 26 | 26 |
| 6'4" 193.0 | 12 | 12 | 13 | 14 | 14 | 15 | 15 | 16 | 17 | 17 | 18 | 18 | 19 | 20 | 20 | 21 | 22 | 22 | 23 | 23 | 24 | 25 | 25 | 26 |

**BODY MASS INDEX:**

**HEIGHT:**

**BMI:**

**CATEGORY:**

### WHAT ARE YOUR PRIMARY AREA(S) OF CONCERN?

- ABDOMEN.
- BACK.
- CHEEKS.
- UPPER LEGS.
- HAMSTRINGS.
- SIDES
- CHIN
- ARMS (TRICEPS)
- INNER THIGHS
- BUTTOCKS

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# Body Contouring CLIENT GOALS

Do you want to tighten skin on your body? Yes ○ No ○
If yes, from what area(s)? _____

Do you want to tighten skin on your neck/face? Yes ○ No ○
If yes, from what area? _____

Please list your regular exercise habits:
_____

Please describe your current dietary habits:
_____

How many ounces of water do you drink daily?
_____

Women, please list your last date of menstruation: _____
*Do not schedule Non-Surgical Lipo, Cavitation, or RF Skin Tightening treatments during your cycle* (cycle will become heavy)

I consent to taking photographs for progress charting. _____ (initials)

## EXPECTATIONS

This is an important decision towards improving your wellness and overall lifestyle! We share the mutual desire of you reaching all of your wellness goals involving Body Contouring. In order for you to reach these goals, we have provided a few points to educate you on achieving your best results. It is important to manage your expectations according to an appropriate diet, lifestyle and exercise program incorporated in conjunction with your Body Contouring treatment protocol.

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# Body Contouring CONSENT FORM

I understand that the Body Contouring I receive is provided for the basic purpose of improving the flow of my lymphatic system and also for relaxation. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort.

I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such.

Because massage/ bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.

***Please Note: Body contouring is a very powerful modality and certain medical conditions are contraindicated and determine if and when you can receive a session. After the consultation and review of the information you have provided on this form, it will be determined if body treatments should be administered to you today. Some conditions will require a note from your doctor before proceeding. Please understand this is for your safety and well-being.**

**Client Name: _____Date_____**

**Body Sculptung Tech. Signature _____Date _____.**

**Consent to Treatment of Minor: By my signature below, I hereby authorize (YOUR NAME), to administer body contouring techniques to my child or dependent as they deem necessary.**

**Signature of Parent or Guardian _____ Date_____**


# Body Contouring

# TERMS OF ACCEPTANCE

Please read carefully and understand the contents of this form. Ask us if you not understand. When a client seeks Body Contouring services and when the service provider accepts a client, it is essential that both are seeking and working for the same goals. We expect our clients to take full responsibility for their decisions to participate in any of the services/programs offered by this office. We do not identify, diagnose, or treat ANY condition or disease.

We have only one goal: **TO OPTIMIZE YOUR BODY'S ABILITY TO FUNCTION NORMALLY AND OPTIMIZE YOUR FAT-BURNING POTENTIAL**. By reducing bio-stress levels, we allow the body's inborn self-correcting mechanism to work at maximum efficiency to restore, maintain and promote wellness.

We do not identify or diagnose any condition(s) or disease(s). We offer no treatment for any condition(s) or disease(s). We promise no cure from any disease(s) or condition(s). Instead, we facilitate your body's own self-correcting mechanism.

It is essential that you speak to your doctor prior to making any decisions about altering any medical regimen you are currently following, changing your diet, taking supplements, or going on an exercise and/or weight loss program. Getting your doctor's approval prior to starting any service/program at our office is critical and solely your responsibility. Should any health condition arise while you are a client, we recommend that you immediately see the appropriate health care provider. Any options that are rendered by the staff and/or head personnel should NEVER be construed as medical advice but merely as opinions. If you like medical advice, please see one of our medical doctors. We will not deal with any medical condition.

With your signature below, you understand and accept the risks and agree that neither the provider, its staff, will be liable for any injury to you, including, but not limited to, personal bodily injury, death, mental injury, economic loss or any damage to you, your spouse, or relatives resulting from any act of the service provider, and its staff or anyone else using the facilities and that you acknowledge the inherent risks of the positions, movement, dietary/nutritional programs offered to and done to you at the service provider, with respect to your current or past condition(s). If there is any dispute between you and the service provider, and/or any of its staff, both parties agree to submit it to binding arbitration. We both agree to have a neutral arbitrator preside over any such dispute, not a judge or jury. **I, the undersigned, understand and accept the conditions as laid out in the "Terms of Acceptance" above.**

**Client Signature _____ (if minor, parent's signature)**

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# Body Contouring CLIENT GOALS

## TREATMENTS QUESTIONNAIRE

Treatments you are interested in or have questions about?
Tick any which applies to you:

- RF Skin Tightening/Cellulite Reduction $100hr.
- Ultrasonic Cavitation $100hr
- Infrared Sauna Blanket $90hr
- Non-Surgical Butt Lift $100hr
- Wood Therapy $75 30min.
- Vibration Plate $50 30min
- Infrared Light The $50 30min

Have you ever had any of these treatments before? Yes No
If yes, what did you like about it?
What didn't you like about it?

What is your primary area(s) of concern?

1st _____ 2nd _____ 3rd _____

What are your overall body slimming & contouring goals?

Do you want to lose body fat? Yes No
If yes, from what area(s)?

Do you want Cellulite reduction?
If yes, from what area(s)? _____

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# Body Contouring SERVICE AGREEMENT

The following provisions apply to the services to be performed for (_____)

**PAYMENT: Deposit due at time of booking $65; $450 (5 sessions)** Payment in full is to be made prior to the start of any program. **(_____)**

**CLIENT COOPERATION:** This Agreement contemplates full Client cooperation in the course of services agreed upon. This cooperation includes Client's agreement to remain active in the recommended program for body contouring visits. The Client recognizes that compliance with recommended services and service schedule is important and the Client agrees to follow the service plan and the course of treatment agreed upon. The Client understand that lack of cooperation, failure to keep appointments and engaging activities identified by the office as potentially counterproductive to the body may necessitate additional treatments to those otherwise provided for this Agreement. Our office policy requires 24-hour advance notice for appointment cancellation. Failure to do so may result in deduction of pre-paid visits. **(_____)**

**TERMINATION:** Subject to the provisions of paragraphs 5 and 6 of this Agreement, the Client may discontinue care and terminate this Agreement at any time by written notice to that effect delivered in person, or by mail, to the office. Such "notice of termination" shall discharge the office from all further obligations and/or duty to render care to the client. The office reserves the right to terminate this Agreement in its sole discretion notwithstanding any other terms or provisions of this Agreement. **(_____)**

**NO REFUNDS IN THE EVENT CLIENT TERMINATES AGREEMENT:** To encourage commitment and follow-through, the service provider offers no refunds. No refunds will be made on body contour treatments. There will be no exceptions. The prepaid program cannot be altered, shared or transferred, nor can it be combined with any other program. **(_____)**

**A 24-hour cancellation notice is required otherwise the non-refundable deposit placed during booking ($15 lashes & teeth Whitening) -$65 (Body Sculpting) depending on number of services) will be lost. All costs are payable in full prior to initial treatment and are Non-Refundable. (_____)**

**TIME LIMITATION FOR SERVICES:** Client understands that unused visits will expire if not used within 120 days from the date Client starts the treatment unless the Office has been provided with advance notice in writing for leave of absence or other cause of delay. After 24 weeks, all outstanding services/visits will be void.. **(_____)**

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# Body Contouring SERVICE AGREEMENT

**NO GUARANTEE OF RESULTS**

Client recognizes that neither Office personnel nor this Agreement provides a guarantee of results. The Office makes no guarantee of the extent or longevity of improvement to be expected. This Agreement deals solely with the services to be rendered and the fees to be paid for the care as provided. The Client's payment obligation is not contingent upon the outcome of services. Client's results can be hindered and/or suppressed by the consumption of the following, but are not limited to, alcohol, processed foods including, but not limited to, sugar-based foods and drinks, etc. It is recommended to consult your physician for dietary modification clearance if you have any questions or concerns.

**RELEASE OF LIABILITY**

Client agrees to indemnify, hold harmless and release the service provider, its agents, employees, officers, directors, representatives, assigns, members, affiliated organizations, and insurers, and others acting on the Company's behalf, of all claims, demands, causes of action, and legal liability, whether the same be known or unknown, anticipated or unanticipated, and further agrees that except in the events of the Company's gross negligence or willful and wanton misconduct, no claims, demands, legal actions and causes of action, shall be made against the Company for any economic and non-economic losses of any kind. **(Initials)**

**COMPLETE AGREEMENT**

**This Agreement constitutes the complete agreement and understanding between Client and Office and will not be changed or modified in any way unless agreed to from both parties in writing. (  )**

**GOVERNING LAW**

**This Agreement shall be governed, construed and interpreted, through and under the Laws of the State of ___Conneticut_..**

**THE CLIENT HAS FULLY READ THIS AGREEMENT AND ANY SUPPLEMENT HERETO, AND UNDERSTANDS AND AGREES TO ABIDE BY ALL OF THE TERMS HEREOF.**

**Client Signature** _____**Date**_____

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# Body Contouring TREATMENT ADVICE

## ENSURE YOUR BEST RESULTS

- Drink plenty of water before and after treatment(s)
- Don't eat 1 to 2 hours prior or following treatment(s)
- Perform physical activity following each treatment to maximize your results
- Manage caloric intake; excess calories will counteract the laser treatment
- Alcoholic beverages and high sugar content drinks must be avoided before and after treatment(s)
- Results vary based on individual body types.
- You will not experience any discomfort from the gels used during your treatments
- Rarely clients experience any discomfort during a session but in some cases a little warming may appear this will end when the treatment ends however if it's too hot please advise your technician to lower temp.
- Generally, clients can expect to see .05 inches to as much as 2.0 inches during treatment term
- If the client consumes the recommended water consumption it increases the results of the treatment.

## LIMITATION TO TREATMENT

____ I understand there are no guarantees as to the results of this treatment
____ I understand that to achieve maximum results, I may require several treatments
____ To achieve optimum results, I understand that an appropriate diet and regular exercise will assist to sustain and create accumulative degree of overall spot fat reduction and body contouring.
____ I understand that like liposuction surgery, non-invasive procedures do not rid the body of visceral fat.

## POSSIBLE SIDE EFFECTS

**Diarrhea:** when fat is successfully broken down, it must exit the body ass tool. You mayor may not notice an increase in bowel movements. Typically, diarrhea is mild and lasts no longer than 36 hours.

**Increased urination:** loss of water from your tissues is normal following the procedure and is a good sign that you are removing fat from your body. Fat enters the blood from the lymphatic system, increasing the "thickness" of the blood (oncotic pressure), and pulling water from tissues to carry the fat to the bowel for removal.

**Flu-like symptoms**: this is rare but can occur due to toxins in the fat being removed via the lymphatic system, causing congestion. Congested lymph pathways can lead to aches, pains, water retention, soreness, and flu-like symptoms.

Increased Hunger: this is the body's attempt at returning to normal by re-accumulating fat. Do not increase food consumption! Follow a low carb, high protein, high fiber diet to combat hunger pains.


# Lash Consent Form

Name _____

Address_____

_____

City _____ State _____ Zip _____

Phone _____ Email _____

**Questions For Client**

Do you wear contact lenses? ☐ Yes ☐ No

*Have you had eye lash extensions before? ☐ Yes ☐ No

*Any reaction or sensitivities? ☐ No ☐Yes If yes _____

_____*

*Do you have any allergies? ☐ No ☐ Yes If yes explain: _____

_____*

*Any eye problem if the last 4 weeks? ☐ No ☐ Yes If yes explain: _____

_____*

*Do you perm or tint your lashes? ☐ No ☐ Yes

*Do you use eye products? ☐ No ☐ Yes If yes explain: _____

_____

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I authorize XS BeautyCare to apply eyelash extensions to myself today and other future services. I understand that aftercare is needed to maintain health of eye lashes, including refills 2 to 3 weeks from initial service date. I hereby release all person(s) at XS Lashes/XS Beauty & Care from all claims or legal actions arising out of a service. I give consent for photographs to be taken and used on social media and any other form of marketing.

☐I certify that I completely understand and comply with the above as stated.

Signature _____ Date _____