Slim You LASER SPA

Client Information

Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Email Address _____ Occupation _____

Employer _____ City _____

Cell Phone _____ How did you hear about us _____

Emergency contact name _____ Telephone _____

Reason for Visit

Areas of Interest for Treatment ____ Outer Thighs ____ Inner thighs _____ Arms _____

Under Chin _____ Hips _____ Muffin Top _____ Abdomen _____

Do you have any Tattoos _____ How recent _____

Health History

Do you have, or have you ever had the following:

Epilepsy _____ Cancer ____ Skin Cancer _____ Thyroid Dysfunction _____ Uncontrolled Hypertension _____

Pacemaker _____ Heart Disease or Arrhythmias _____ Liver or Kidney Disorders_____

Are you pregnant_____ Date of last menstrual period _____

Medical History

Conditions or surgeries related to weight (or could affect your weight) _____

_____

Current Medications _____

Do you drink soda _____ if yes how many per day _____

Name_____ Date _____

Signature _____