

SIGNATURE-CUSTOMER



DATE

CLIENT INFORMATION FORM

PERSONAL INFORMATION										
Name:	Dat	te of Birth:		Age:	□ Male □Female					
Address:	City:									
Email:	Sta	te:		Zip:	Zip:					
Profession:		rent ight:	Heigl	nt:	Min Adult Weight:					
Cell Phone:	Ho	me Phone:			Max Adult Weight:					
Referred by (How did you hear about us?):										
MEDICAL HISTORY										
Allergies: 🗆 Latex 🗆 Other:										
History of past or current medical conditions: (Please check all that apply.) I am over 18 with proof of identification I am not pregnant or breastfeeding I have no cardiovascular disease or disorder(ex. pacemaker, defibrillator) I have no known liver disease or disorder I have no known kidney disease or disorder I do not have cancer(active or within 1 year of remission) I do not have a compromised immune system		□ I do not have uncontrolled Hypertension □ I do not have any lymphatic disease or disorder □ I do not have any diseases or disorders stimulated by heat (ex. herpes simplex) □ I do not have any diseases or disorders stimulated by light (ex. epilepsy, lupus) □ I do not have any retinal detachment □ I do not have any skin lesions □ I have no known thyroid gland dysfunctions □ I have no known photosensitivity to sun exposure □ I am not taking medication which causes any photosensitivity								
PHOTOGRAPHY										
□ I consent to taking before and after photographs and authorize their ANONYMOUS use for the purpose of medical audit, education, and/or promotion. Initial Here:										
ACKNOWLEDGEMENT										
□ I understand that there are no guarantees to the results of this treatment. I understand to achieve maximum results, I may require several treatments. □ It has also been recommended to achieve optimum results, I understand that an appropriate diet and regular exercise will assist to sustain and create a cumulative degree of overall fat reduction and body contouring. □ I have been informed and understand that temporary hyper-pigmentation/hypo-pigmentation on rare occasion may occur as a result of treatment. □ I understand that there is a 24 hour cancellation policy for all appointments. Any no show or late cancellation/reschedule will be counted against any prepaid sessions. I confirm that the answers to the questionnaire are true and correct to the best of my knowledge. I also confirm the staff explained the treatment(s) and answered my questions.										

PRINT NAME





EXERCISE HABIT	S												
On a scale of 1 to 10, indicate what level of importance you give to losing weight: (circle one)													
											ne)	.,	
Least important	1	2	3	4	5	6	7	8	9	10		Very important	
Do you exercise? Yes No If yes, what kind?													
How often?				Daily			Wee			Other	:		
Have you been on a c	diet bef	fore?		•			Yes	•		No			
If yes, please specify which diet(s) and why you think it didn't work for you (i.e. too rigid, too much cooking involved, etc.)													
EATING HABITS													
(Please provide hone	st ansv	vers so	that v	ve can h	elp you	1)							
BREAKFAST													
Do you have breakfas	st every	/ morn	ing?					Yes		No		Never	
Approximate time:													
Examples:													-
Do you have a snack	before	lunch	?					Yes		No		Never	
Approximate time:													
Examples:													-
LUNCH													
Do you have lunch ev	ery day	y?						Yes		No		Never	
Approximate time:													
Examples:													=
Do you have a snack	hafara	dinna	r)					Yes		No		Never	
Approximate time:	Deloie	ullille	1:				Ш	163	Ш	NO	Ш	Nevel	
Examples:													
·													
DINNER Do you have dinner e	verv da	av?						Yes		No		Never	
Approximate time:	, ,	-, .							ш	110			
Examples:													
Do you have a snack	at nigh	+7						Yes		No		Never	
Approximate time:	at 111611						ш		Ш	110	Ш	116161	
Examples:													-
						,							

The Spa at Mecca - 333A Route 46W Suite 135 - Fairfield, NJ 07004 - www.meccaspa.com - (973) 943.4300