



Body Contouring (Cupping)

Help us achieve success by filling out this questionnaire as completely as possible.

Name: _____ Date: _____

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

Email: _____ Birthday: _____

What body areas would you like to focus on? _____

What treatments would you like to know more about? _____

How did you hear about us? _____

Medical History:

Please check all that apply.

- ☐ Pregnancy or nursing (current only)
- ☐ Heavy periods/bleeding
- ☐ Dental implants, caps, metal fillings (circle all that apply)
- ☐ Botox or filler in treatment area
- ☐ Pacemaker or internal defibrillator, implanted neuro stimulators or any other
- ☐ Metal implants or other implants in treatment area (i.e. IUD, screws, plates, etc)
- ☐ Current or history of cancer - especially skin cancer or pre-malignant moles in treatment areas
- ☐ Impaired immune system due to immunosuppressive diseases such AIDS & HIV or use immunosuppressive medications
- ☐ Chemical sensitivities such as reactions to cosmetic products or perfumes. If known, please list offending ingredients: _____.
- ☐ Varicose veins in the treatment area
- ☐ History of skin disorders such as keloid scarring, abnormal wound healing, as well as very dry and fragile skin
- ☐ Any surgical, invasive, ablative procedure in the treatment area before complete healing
- ☐ Skin blotches or rosacea
- ☐ Severe concurrent conditions such as cardiac disorders or epilepsy
- ☐ Condition which could be adversely affected by Heat.
- ☐ A history of diseases stimulated by heat, such as recurrent Herpes Simplex in the treatment area or active Herpes
- ☐ Areas of sensory impairment such as in cases of nerve lesions and neuropathies
- ☐ Any active condition in the treatment area, such as sores, psoriasis, dermatitis, eczema and rash as well as excessively /freshly tanned skin
- ☐ Acute hernia, discopathy, or spondylolysis
- ☐ Severe diabetes
- ☐ Herniated spinal disc
- ☐ Recent infection: (please explain) _____
- ☐ _____
- ☐ Continuous use of Retin A, retinol
- ☐ Medications such as blood thinners
- ☐ Any medical condition that might impair skin healing
- ☐ Active weeping acne
- ☐ Hip, knee, or shoulder implants
- ☐ No Health Issues Listed Above

Contraindications:

No open wounds (raw tissue) • no contagious skin conditions (chicken pox/herpes/blisters) • bulging or herniated disc or dislocated injuries • no acute inflammation or recent injuries • sprains • strains • fractures • surgeries • no face cupping during pregnancy (or recent cosmetic injection) • no long or prolonged cupping if taking blood thinners • no eczema/psoriasis if areas are red, inflamed, or cracked • no new tattoo (before 4 weeks) • no cupping on varicose veins

Post-Surgical Contraindications: (must be 8-wks post-op w/surgeon consent)

Eyelid lift • face lift • tummy tuck • liposuction

*MUST RECEIVE MEDICAL RELEASE FROM SURGEON TO RECEIVE CUPPING BODY WORK
"invigorating massage"

I have been informed of the potential risks and side effects of all procedures and treatments including but not limited to redness, swelling, heat sensitivity, pain, increase bowel movements, and increased urination. The risks, potential damages and adverse side effects have been explained to me and by honestly completing this form, I acknowledge that I fully understand.

_____(initial)

Cancellation/Reschedule Policy

We are requesting that you please call if you are unable to make a Body Contouring session or Consultation appointment. All appointments missed without notifying us ahead of time will not be able to be made up due to the effect "no shows" have on our scheduling process. If prior notice is given, your appointment and/or consultation will be able to be made up. We are always glad to reschedule an appointment as we understand that unexpected conflicts do come up. Please call and we will do our best to get you the most convenient time for you.

If I am more than 10 minutes late for an appointment, without calling, Changes City Spa may not guarantee I will be seen. If my therapist cannot fit me into the appointment schedule, I will be charged half of the total appointment fee.

_____(initial)

Once sessions are started there are no refunds provided. You may use the remaining sessions for up to 6 months after written notice is provided.

_____(initial)

I UNDERSTAND THAT THIS IS MY RESPONSIBILITY TO KNOW THE TERMS OF MY AGREEMENT AND I AGREE TO COMPLY WITH THE TERMS.

I HAVE READ AND AGREE TO ALL TERMS OUTLINED ABOVE

Signature of Guest

Date