NEW YOU
BODY SCULPTING

New You Body Sculpting Intake Form

Your success is our #1 priority but this takes your commitment as well.

Please fill out this confidential form as detailed as possible.
We will review this with you during your initial consultation.

Date:_____

Name _____ Date of Birth_____

Street Address: _____

City: _____ Zip Code: _____

Cell phone number (with area code): _____Carrier_____

Your email address:_____

What is your profession, or where do you work? _____

Are you generally sitting at work or is there physical labor? _____ _

Hobbies: _____

How did you hear about us? newspaper___ radio___ magazine___ flier___ other_____

Or did a friend refer you to us? _____ If yes, who sent you? _____
Where do they work? _____What's their phone # _____
We want to be sure to thank them with a gift for the referral! (and we will do the same when you refer a friend!)

Your Real Age _____ Is this the age you feel? Y/N Younger or Older _____

Height _____ Current Weight _____

What body area(s) do you want to tackle? _____
What do you want to weigh, or what clothing size do you want to reach?_____
Any idea on how many inches you want to lose and from where? _____
How soon do you want to reach that goal? _____

Does your family and or friends support you in your health goals? Circle what applies:

100% support not really supportive I could use a support system

What's your biggest struggle related to your health, weight loss, or healthy eating _____
_____

These treatments can take a minimum of 6 weeks of consistent visits, 2 times a week. Do you have any upcoming extended trips planned in the next 60 days? yes/no

Are you currently under the care of any doctor? _____ If yes, why?_____

Have you had any recent surgery? _____ If yes, please explain: _____

What ways have you tried losing weight in the past? List products, companies, programs.

_____

_____

Have you ever had any procedure for weight loss? _____

Do you feel like nothing ever permanently works when it comes to weight loss? _____

If yes, why? _____

Are you currently a member of a gym? _____

Do you regularly exercise? _____ How often in a week? _____

What do you do for exercise? _____

To help flush the fat, you MUST exercise at least 6 days a week for a minimum of 30 minutes, even if it's a brisk walk through your neighborhood? Will you? yes/no

Could you benefit from

Improved nutrition? **yes/no**

Having more energy? **yes/no**

Sleeping better at night? **yes/no**

Do you have a hard time getting out of bed in the morning? **yes/no**

Do you have any aches or pains **yes/no** What hurts? _____

Do you take naps? **yes/no** If yes, how often? _____

How often do you eat fast food? ____ How many times a week? _____

List the fast food places where do you often eat _____

What do you usually order? _____

What do you regularly drink? Circle all that apply.

milk coffee water soda energy drinks juice wine beer liquor other: _____

Of those you circled, how many glasses or cups do you have in an average day. Please write the number of glasses or cups below the drink above.

List any and all medications you are currently taking. (This matters when it comes to weight loss.)

_____

_____

_____

Please list any vitamins, herbs or supplements you take on a regular basis.

_____

_____

Do you have any daily aches and pains? Please list those below.

_____