SPRINGS BODY
SCULPTING & AESTHETICS
DEFINE YOURSELF

Patient Info

Full Name: _____Date_____

Date of Birth: _____Sex: Male / Female

Address: _____

Home Phone #: _____Cell Phone #:_____

Email Address: _____

How did you hear about us? _____

Medical History

Do you have any of the following? ***(Please mark YES or NO to all)***

PLEASE CHECK ALL THAT APPLY:

Pacemaker/Defibrillator	YES / NO
Pregnant or nursing	YES / NO
Impaired Immune System	YES / NO
History of bleeding disorders	YES / NO
Diabetes - Type 1	YES / NO
Diabetes - Type 2	YES / NO
Heart Conditions	YES / NO
Saphenous insufficiency	YES / NO
Smoker	YES / NO
Metal Implants	YES / NO
Injection / Fillers	YES / NO
Tanned skin	YES / NO
Tattoo / Permanent Makeup	YES / NO
Diseases stimulated by light (Lupus, Epilepsy, etc)	YES / NO
Diseases stimulated by heat (Herpes simplex, etc)	YES / NO
Previous surgical procedures	YES / NO
Severe concurrent medical conditions	YES / NO
Active Skin infection (Psoriasis, Eczema, etc)	YES / NO
Skin disorders (Keloids, abnormal wound healing)	YES / NO
Use of medication / herbs inducing photosensitivity	YES / NO
Facial Laser resurfacing / Deep chemical peels in last 3 months	YES / NO
Needle epilation, waxing or tweezing in last 6 weeks	YES / NO
Current/history of skin Cancer/other cancer/pre-malignant mole	YES / NO
Hernias or previous abdominal surgeries	YES / NO

Are you currently under the care of a physician? YES / NO If yes, for what _____

Are you pregnant or trying to get pregnant? YES / NO

Do you have any allergies? YES / NO If yes, please list allergies_____

What medications are you presently taking?_____

Have you taken Accutane or any other acne medication in the last 12 months? YES / NO
If YES, please list medication and dosage_____

Do you have **ANY** conditions that you take meds for? If so, please list:

_____

Current weight: _____ Height: _____

Other considerations: _____

What is the main concern that brings you to our office?_____

What are your expectations for today's visit? _____

Do you regularly sun bathe or use tanning salons? YES / NO How often? _____

Have you ever had Botox or dermal fillers? YES / NO If yes, When were you last treated:_____
Any complications? YES / NO If yes, please specify:_____

Have you taken any Aspirin, Ibuprofen, Motrin, Tylenol, Fish Oil, Vitamin E, Blood Thinners, Alcoholic Beverages in the last 10 DAYS? YES / NO If yes, what?_____

I certify that the preceding medical, medication and personal history statements are true and correct. I am aware that it is my responsibility to inform the doctor or other health professional of my current medical health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

_____	_____	_____
Print Your Name	Signature	Date

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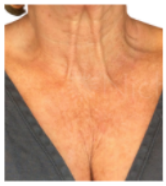
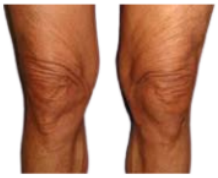
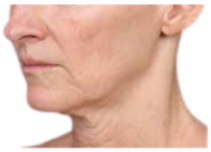
PATIENT INTEREST QUESTIONNAIRE

Full Name: _____Age_____ Date:_____

Please indicate any areas of concern for you - check ALL that apply:

- ☐ Love Handles 
- ☐ Belly Fat 
- ☐ Loose Chest Skin 
- ☐ Cellulite 
- ☐ Back Fat 
- ☐ Saggy Knees 
- ☐ Loose Arm Skin 
- ☐ Loose Neck Skin 
- ☐ Veins 
- ☐ Thigh Fat 

Other Areas of Interest: (Circle ALL that apply)

♥ Breasts ♥ Buttocks ♥ Hair Removal

4114 Austin Bluffs PkwyColorado Springs , CO 80918
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(719) 387-0630

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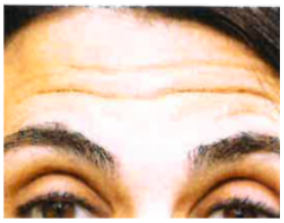
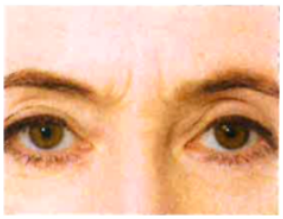
Full Name: _____Age_____ Date:_____

☐ Forehead Lines

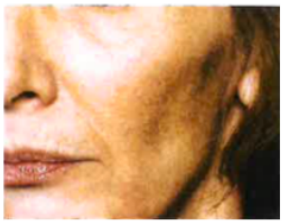


☐ Frown Lines

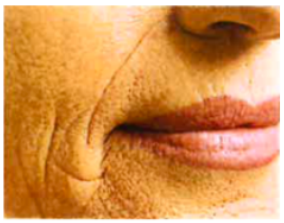


☐ Crow's Feet Lines

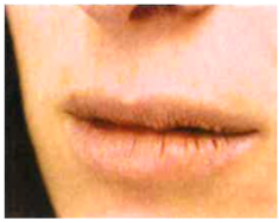
☐ Flattened/Sunken Cheeks



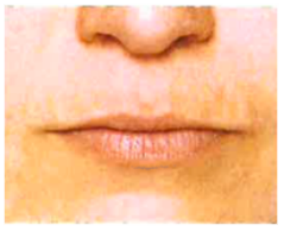
☐ Lines & Wrinkles Around Nose & Mouth



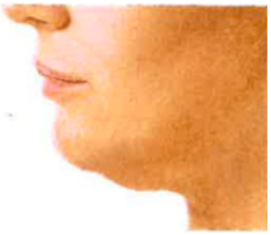
☐ Lip Appearance & Texture



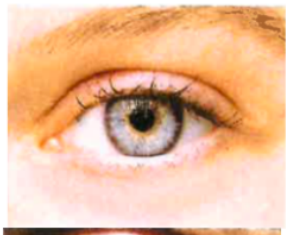
☐ Thin Lips



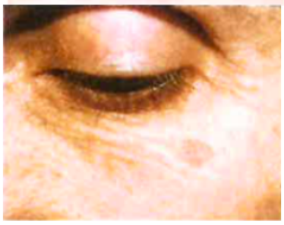
☐ Double Chin / Jowls



☐ Thinning or Inadequate Lashes



☐ Skin Appearance & Texture



Areas of Interest for Treatment: (Circle ALL that apply)

Botox: "Elevens" Forehead Crow's Feet Sweaty Palms/Soles TMJ

Filler: Lips Wrinkles Cheeks "Liquid Facelift"

Dark Spots | **Scarring** | **Skin Care** | **Neck/Under Chin Fullness** | **Broken Blood Vessels in Face**

Acne Scars | **Facials** | **Microneedling** | **Chemical Peels** | **Eyelash Enhancement**

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