Client CONSULTATION Form for Infrared Body Wrap

Client Name: _____ **Date:** _____

The purpose of this is to identify the needs of your body—so that we can give you the *best possible solutions.*

What challenges or concerns are you having with your body right now? Weight – Fatigue (toxins) – Pain – Cellulite

_____ _____ _____

_____ _____ _____

Where is the problem located? (pain) _____

Have you had past treatments to address these concerns (circle)**?** Yes No

If yes, what would you rate the effectiveness of the treatments on a scale of 1 – 10 *(10 being the best)* _____

How would you rate the *elasticity* of your *skin*?
a) Tight & firm
b) Moderately firm
c) Loosing elasticity
d) Loose & saggy

How would you rate the *appearance* of your body?
a) Petite
b) Average
c) Athletic
d) Over-weight

What would you rate the *condition* of your body right now on a scale of 1 – 10 *(10 being the best)*? ____

What would you like it to be? _____

Your specific goals? (dress size, weight, an old pair of jeans, swimsuit) _____

Is your goal (circle one)? short term long term lifestyle change

What would you rate your commitment level to addressing these concerns on a scale of 1 – 10? ____

Do you exercise? YES / NO **What types?** _____ **How often/how long?**_____

Have you ever had a negative reaction to raised blood pressure? Yes No

Ø If yes, check with their doctor first and get permission before doing wraps Ø

Do you have any major scars, rods, pins, plates? _____

What does your diet currently look like?

Amount of Water Daily: _____ Typical foods: _____

Pop/Soda/Energy Drinks: _____ Snacks/Treats: _____

Artificial Sweeteners: _____ Other: _____ _____

Food Allergy/Gluten Sensitivity etc _____

What is the ONE thing you *most* want to see *change* or *improve*? _____

The Top 3 Challenges I heard you say were:

1. _____

2. _____

3. _____

The Solutions I Recommend: (Wraps, gel, supplements)

_____

_____

_____