



Lyopassage

Client Questionnaire

Client Name: _____

Client Number: _____

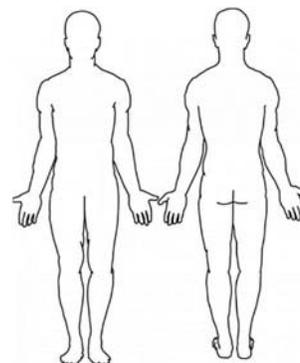
- Thyroid Treated ok
- Hypertension Treated ok
- Heart Disease Treated ok
- Varicose Veins Not in that area or work around
- Phlebitis No
- Cancer/Malignancy No Active
- Diabetes Ok
- Easy Bruising Make aware may bruise (Small)
- Skin Rash Ok if not contagious
- Open Sores Not in that area
- Herpes I (Active) No if Active
- Herpes II (Active)
- Herniated Disc Ok
- Are you Pregnant No
- Are you taking medication _____ If so, The Name of the Medication(s) and why are you taking them?

Have you ever had Professional Massage before? Was it a Positive _____

Do you have Difficulty lying in any Position and if so what Position? _____

What is your Lyopassage goals?

Circle Problem Areas



Have you ever had cosmetic surgery or liposuction? if so, where and was the experience Successful?

Informed Consent

I understand that lyopassage is not a massage treatment as much as it is a "body Contouring method" of body work. I am aware that in practicing this method no attempt is made to diagnose illness or disease or any other disorder and that the practitioner doing the lyopassage body contouring method will not prescribe or preform spinal manipulations as part of the lyopassage body contouring treatment. It is further understood that I will keep my doctor and the lyopassage practitioner aware of any and all physical or mental changes during the lyopassage program period. I have stated all my known medical conditions. I am also aware that my body worker is a certified lyopassage practitioner.

Client Signature: _____ Date: _____

Lypossage

I Agree to the following conditions of my lypossage body contouring program:

- To keep all of my lypossage Appointments
- To maintain (At Least) my normal eating habits
- I consent to being photographed at the beginning and at the end of the series for the purpose of recording changes in the target areas
- I consent to be measured at the beginning, the middle and at the end of the series, for the purpose of recording changes in the target areas
- I will report any significant health issues that may occur during the lypossage body contouring program
- I am aware that all files, photographs, and measurements are the property of Circle of Wellness
- I give my permission for Circle of Wellness to publish statistical data and photographs derived from my lypossage body contouring program

(Signature)

(Date)

(Print Name)

(Street Address)

(City)

(State)

(Zip)

Telephone Number: _____