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**Body Contouring Questionnaire**

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*What areas are you interested in having contoured?*

Arms      Breasts      Abdomen      Waist      Saddlebags      Face/neck  
 Love handles/flanks      Thighs      Buttocks      Hips      Knees      Other \_\_\_\_\_

*What is your height?* \_\_\_\_\_ *Weight?* \_\_\_\_\_ *What weight do you hope to maintain?* \_\_\_\_\_

*Have you gained weight in the past 5 years?* \_\_\_\_\_ pounds. *If so, has your activity pattern changed?* Y / N

*If yes, how has it changed?* \_\_\_\_\_

*Have you lost weight in the past 5 years?* \_\_\_\_\_ pounds. *If so, how?* \_\_\_\_\_

*What is the most you've weighed?* \_\_\_\_\_

*Do you have a bleeding tendency?* Y / N *Have you ever had phlebitis (blood clots)?* Y / N  
*Do you bruise easily?* Y / N *What is your clothing size? Female (dress)* \_\_\_\_\_ *Male (waist)* \_\_\_\_\_

*Are you on any medication?* Y / N *list* \_\_\_\_\_

*Do you exercise?* Y / N *explain* \_\_\_\_\_

*Do you have skin irritation where skin is touching skin all the time?* Y / N

*If yes, what is your regimen of treatment?* \_\_\_\_\_

*Have you sought treatment from your primary care doctor for these rashes including prescription creams?* Y / N

*Give detailed information:* \_\_\_\_\_

*If your abdomen is your problem area, do you note lower back pain?* Y / N

*How long have you noted these symptoms?* \_\_\_\_\_

*Have you had examination or treatment ordered by your primary care doctor, chiropractor, orthopedic doctor, or physical therapist, for other possible causes of your pain?* Y / N

*Have you tried Chiropractic Care?* Y / N *Physical Therapy?* Y / N *Massage Therapy?* Y / N

*Details* \_\_\_\_\_

*Do you ever take prescription medication/ analgesics (aspirin, Tylenol, Motrin, ibuprofen, etc.) for this pain?* Y / N

*We may need to contact you and/or any of the above mentioned physicians for documentation for your insurance company. We will need your assistance and cooperation with this process.*