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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 your lost weight in the past 5 yea _____

What is the most you've weighed? ___ _____

Do you have a bleeding tendency? Y *clots)? Y / N*
Do you bruise easily? Y *(dress)* _____ *Male (waist)* _____

Are you on any medication? Y _____

Do you exercise? Y _____

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 you assistance and cooperation with this process.