Body Therapy Consultation Form

Name: _____ Competitor Number: _____

We aim to ensure models have the best possible treatment from our competitors. Please read the following information and check off contraindications that apply to you.

Are you currently taking any medications? YES NO

If yes, please list what medications you are on.

_____

_____

_____

_____

With respect to your body, please indicate any of the following that may pertain to you.

Condition	YES	NO	Notes
Allergies			
Arthritis			
Diabetes			
Joint Replacement(s)			
Low/High Blood Pressure			
Fibromyalgia			
Numbness			
Sprains/Strains			

With respect to your feet, please indicate any of the following that pertain to you.

Condition	YES	NO	Notes
Dry Feet			

Cracked Skin			
Itchiness			
Peeling Skin			
Skin Fungus			
Discolored Nails			
Thick Nails			

With respect to your head/neck, please indicate any of the following that pertain to you.

Condition	YES	NO	Notes
Cuts/Abrasions			
Bruising/Swelling			
Skin Conditions (Eczema, Dermatitis, Psoriasis)			
Contagious Conditions			
Migraines			
Vertigo			
Recent head/neck injuries			

I have answered all the above questions to the best of my knowledge.

Model signature: _____