DR MANJIRI'S
INSTA SCULPT
Figure | Face | Hair

Sr. No.: _____

Consultation Form

Date: _____

Centre: _____

Advisor: _____

> "Add life to years, not years to life."
>
> - Dr.Manjiri Puranik
> MBBS, MD

(The below mentioned data would be kept confidential and used for treatment purpose only.)

Name: Dr. / Mr. / Mrs. / Miss _____

Gender: Male ☐ Female ☐ Date of Birth (dd/mm/yy): _____

Mobile No.: _____ Tel No. Resi / Of ce: _____

Email: _____

Address: _____

_____

Marital Status: Single ☐ Married ☐ Others ☐

Profession: Service ☐ Business ☐ Home Maker ☐ Student ☐ Doctor ☐ Media ☐
Government Service ☐ Other, please specify _____

Spouse's Profession: Service ☐ Business ☐ Home Maker ☐ Student ☐ Doctor ☐ Media ☐
Government Service ☐ Other, please specify _____

Have you visited INSTASCULPT before ? Yes ☐ No ☐ If yes, kindly give details _____

How did you know about INSTASCULPT ?
Advertisement ☐ Flyer ☐ Voucher ☐ Event / Activity ☐ Family / Friend ☐
Word of mouth ☐ Emailer ☐ Website ☐ Any Other, please specify _____

_____ _____
Customer's Signature Advisor's Signature

Feedback

Sr. No.	Date	Particulars	Signature

MY HEALTH STATUS

My Age: _____years My Height: _____ft _____ inches My Weight: _____kg

I've been out of shape since _____ months / years.

I eat outside food _____ times a week.

I indulge in Smoking ☐ Consuming Alcohol ☐ Chewing Tobacco ☐ Drinking Tea ☐ Drinking Coffee ☐

Any other, please specify _____

I have a craving for _____food/s.

I have the following medical issues:
Cardiovascular ☐ Hypertension ☐ Diabetes ☐ Metal Implant / Pacemaker ☐ Epilepsy ☐ Spinal ☐
Poly Cystic Ovarian Syndrome (PCOS) ☐ Thyroid ☐ Hyperprolactinemia ☐ Hernia ☐ Gout ☐
Osteoporosis ☐ Arthritis ☐ Bronchial Asthma ☐ Renal ☐ Hyperlipidemia ☐ Psoriasis ☐

Any other, please specify _____

I have been treated / operated for

_____

I am / may be allergic /sensitive to

_____

I am currently under the following medical prescription:

_____

My family medical history

Relation	Particulars

I agree that all the above provided data is genuine and to the best of my knowledge.

_____
(Signature)

FIGURE

Which of the following is the area of concern?
Hanging Abdomen ☐ Sagging Arms ☐ Protruding Tummy ☐ Cellulite on Back & Sides ☐
'Orange Peel' appearance on Hips & Thighs ☐ Bulky Chest ☐

Kind of food you eat:
Junk Food, Farsan, Fried Food ☐ Regular home meals, Minimal eating out ☐ Speci c controlled diet ☐

Number of meals consumed in a day ☐

Type of Diet: Vegetarian ☐ Non-Vegetarian ☐ Ovo-Vegetarian ☐

Exercise:
At the Gym ☐ At Home ☐ Not at all ☐ Any other activity, please specify _____

Kind of Exercise:
Yoga ☐ Cardio ☐ Weight Training ☐ Walk for (distance) ☐ _____(time)_____
Any other Exercise, please specify _____

Frequency of Exercise:
Daily ☐ 5 times a week ☐ 3 times a week or less ☐ No Exercise ☐

Previous treatment Availed:
Crash Diet ☐ Exercise - Supervised / Unsupervised ☐ Weight loss programme ☐ Surgery ☐
Any other please specify _____

_____

FACE

Which of the following is the area of concern?
Hyper Pigmentation ☐ Acne / Pimples ☐ Wrinkles ☐ Puffy Face ☐ Frown Lines ☐
Sagging Skin ☐ Droopy Eyelids ☐ Double Chin ☐ Discolouration / Dullness ☐

Any Other, please specify _____

Previous treatment for Face, specify if any:

_____

Use of Products / home remedies for face, specify if any:

_____

HAIR

Which of the following is the area of concern?
Dull Hair ☐ Hair Loss ☐ Dry & Frizzy Hair ☐ Dandruff ☐ Alopecia areata ☐

Any Other, please specify _____

Previous Treatment for Hair, specify if any: _____