VALORACION

CORPORAL

* ANAMNESIS

NOMBRE:

DIRECCION:

TELEFONO: CEL:

EDAD:

FECHA DE NACIMIENTO:

CORREO ELECTRONICO:

* ANTESCEDENTES PERSONALES:

ALERGIAS: SI ( ) NO ( )

HIPERTENSION: SI ( ) NO ( )

DIABETES: SI ( ) NO ( )

TIROIDES: SI ( ) NO ( )

DIU: SI ( ) NO ( )

TRANSTORNOS CIRCULATORIOS: SI ( ) NO ( )

IMPLANTES METALICOS: SI ( ) NO ( )

PROCESOS (QX): SI ( ) NO ( ) CUALES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ESTA ACTUALMENTE EMBARAZADA: SI ( ) NO ( ) MESES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* INSPECCION
* CELULITIS SI ( ) NO ( ) Donde \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* ESTRIAS SI ( ) NO ( ) Donde \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* FLACIDEZ SI ( ) NO ( ) Donde \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* BIO-TIPO:

GINOIDE ( ) ANDROIDE ( ) MIXTO ( )

* ESTRUCTURA CORPORAL

GRANDE ( ) MEDIANA ( ) PEQUEÑA ( )

* TALLA:
* PESO:
* PESO IDEAL:
* SOBRE PESO: SI ( ) NO ( )
* OBESIDAD : SI ( ) NO ( )
* TRATAMIENTO :

REDUCCION ( ) ESTRIAS ( )

TONIFICACION DE BUSTO ( ) TONIFICACION DE GLUTEOS ( )

CELULITIS ( ) PEELING ( )

TONIFICACION ( )

FIRMA: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CONTROL DE MEDIDAS

|  |  |  |  |  |  |  |  |  |  |
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| FECHA | PESO  Kg | BUSTO | ABD ALTO | CINTURA | ABD BAJO | CADERA | PIERNA | BRAZO | GLUTEO |
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SEGUIMIENTO DEL TRATAMIENTO:

TTO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FECHA DE INICIO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ VALOR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| FECHA | SERVICIO | # DE SESION | PAGO | FIRMA |
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