Lipo-Light

SOUTH BAY LIPO LIGHT _ INTAKE FORM

Your success is our #1 priority.

Help us to help you achieve that success by filling out this questionnaire as completely as possible.

Name**:**_____Date**:**_____

Address**:**_____

Home **#:**_____ Work **#:** _____ Cell **#:**_____

Email**:** _____

Height:_____ Weight: _____ Age:_____ Sex:____

Occupation:_____Marital Status:_____

Are you stressed? (Y/N) Cause of Stress: _____
Are you currently under the care of a physician? (Y/N)
List any current or previous medical conditions that might affect you having this treatment
_____

_____

Do you have any of the following? (any of the following would make you unsuitable):

____ Pregnant or Breastfeeding
____ Cancer (Active or in remission)
____ Auto Immune disease
____ Thyroid Problems
____ Lymphatic problems
____ Kidney/Liver disease
____ Heart Disease/Pacemaker
____ Metal Pins or plates
____ Pacemakers
____ Cardiovascular disease
____ Medical Oedema (excessive build up of fluid in the body's tissue)

Do you smoke? (Y/N)
Do you exercise? (Y/N) How often Per Week? _____ What type? _____
How many cups of Water do you drink per day? _____
Are you currently dieting and watching your food intake? (Y/N)
Are you watching and counting your calories (Y/N)
What worries you most about your body?_____
How did you find us? _____ How long have you been overweight? _____
Who may we thank for the referral? _____
What methods failed to help you lose weight? _____

How fast do you want to be thin, trim, and fit? _____ Ideal weight? _____

Are you embarrassed about your weight? (Y/N)
Family Members Overweight? (Y/N)
Do you need dieting advice? (Y/N)
Would you like nutritional counseling (Y/N)

Is there anything relevant that you need to let us know? _____

What do you expect from your Lipo Light treatment? _____

Circle the most important element in deciding to use our services (check one):

___ Effectiveness (your results)
___ Time (how fast you get results)
___ Service (how we respond to your needs)
___ Affordable (what we charge)

You should note that if the therapist is unable to explain to you the contra indications or is unsure of anything that may apply to a specific condition then they should not treat you without asking you to consult with your primary physician.

It is your responsibility and not that of PWLC staff to consult your primary physician if necessary.

I hereby indemnify the therapist against any adverse reaction sustained as a result of the treatment and confirm that all the information I have given is correct. *By signing this, you also acknowledge there is a strict 24 hour cancellation policy.*

Signed..... Date...../...../.....

LIPO LIGHT SOUTH BAY OFFICE ONLY Initial Consult Date: _____
Last Name _____ First Name _____ F M
Sessions Purchased _____
Adequate Water Intake (Y/N) Adequate Exercise (Y/N) Workouts Per Week ____
Area to be treated _____
Height _____ Weight _____ H1 _____ H2 _____ H3 _____
Area _____ Before _____ After _____
Area _____ Before _____ After _____
Area _____ Before _____ After _____
BMI _____ Suggested Number of Treatments _____

Notes _____