LIPO-LIGHT PATIENT INFORMATION

Name: _____Email:_____
Last First

Address: _____
City State Zip

Social Security No:_____ Age:_____ Birth Date:_____

Employer:_____ Occupation: _____

Home #: _____ Business #: _____ Cell #_____

Whom may we thank for referring you to our office?: _____

Emergency Contact: _____ Contact #: _____

Family Doctor: _____ Address: _____

Doctor Phone: _____

What areas do you want treated with the Lipo-Light? _____

Please check any conditions you currently have or have been treated for in the past.

___ Kidney/Liver Disease
___ Cardiac Arrhythmias or Heart Disease
___ Cancer
___ Pregnancy
___ Medical Edema
___ Auto Immune Disease
___ Thyroid Problems
___ Urine Infection
___ Lipoaspiration < 6 months
___ Infections and Skin Rashes
___ Anti-Coagulant Treatment
___ Any Progressive Inflammatory
___ Piercings
___ Other (explain below)

___ Diabetes
___ Epilepsy
___ Hypertension/Blood Pressure
___ Pacemakers
___ Radiation Treatment
___ Photosensitivity
___ Immuno-Suppressed
___ Any Metal Pins/Plates
___ Phlebitis (Red, Hot Calves)
___ Long Term Cortisone/Prednisone
___ Blood Disease
___ Tattoos
___ Medical Implants
___ Surgeries

_____
_____
_____

Do you exercise? _____ How often? _____ What type? _____

How would you describe your energy level? _____
How much do you smoke daily? _____
How many caffeinated beverages do you drink daily? _____
How many alcoholic beverages do you drink daily? _____

Please check the following reasons you have for wanting to lose weight:

___ Unhappiness with appearance
___ Desire more energy
___ Desire more mobility
___ Want to improve health
___ Want to feel better
___ Special occasion
___ Longevity
___ Want to reduce medications
___ Confidence

What dietary problem areas do you have? (check all that apply).

___ Skipping meals
___ Craving carbohydrates
___ Large portion sizes
___ Too much alcohol
___ Frequent snacking on junk food
___ Eating foods too high in sugar
___ Binging on certain foods
___ Eating right before bed
___ Eating for reasons other than hunger
___ Eating out too often
___ Eating foods too high in fat

What structured weight loss programs have you tried before, how long did you participate, and what were the results?

Program name	Length of Participation	Results
_____	_____	_____
_____	_____	_____

Were you able to maintain your weight loss on any of these programs? Yes No

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and **initial your agreement**.

___ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected.

___ I am to the best of my knowledge not pregnant. Date of last menstrual period (MM/DD/YYYY): ____

___ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

___ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of my health condition.

___ I give my consent to be treated with Lipo-Light and Whole Body Vibration and any additional services I may choose to enhance my results.

___ I acknowledge that I have been given a copy of the Lipo-Light guidelines and price list and that I have read and understood them.

_____ _____

Signature Date (MM/DD/YYYY)