Lipo Laser Questionnaire

Today's Date: _____

First Name & Middle Initial: _____ **Last Name:** _____ **Email:** _____

☐ I wish to opt out of any clinic updates via email.
This includes: newsletters, deals, coupons and promotions.

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____ **Date of Birth:** _____

Age: _____ **Height:** _____ **Weight:** _____ **Gender:** ☐ Male ☐ Female

Emergency Contact Name & Phone #: _____ **Military Veteran:** ☐ Yes ☐ No **Marital Status:** _____

Referred to this office by: ☐ Gym ☐ Health Journal ☐ Email ☐ Radio ☐ Flyer

☐ Friend – Name? _____ ☐ Other_____

What motivated you to try the lipo laser? _____

Are you interested in losing weight? Y/N How many pounds? _____

*** We focus on your ability to be well. Our goals are to first address the issues that brought you to this clinc and second, to offer you the opportunity of improved health, wellness and quality of life. Answering the following questions will give us a profile of the specific stresses past and present that you face and allow us to better assess the challenges to your health potential.*

Which area would you like to focus on for circumference reductions? _____

How many inches would you like to lose? _____

Are there any other problem areas? Yes No

Which areas? _____

What special occasion do you have coming up in the future that you would like to lose inches for?

On average, which of the following reflects your daily eating habits? (Please check all that apply):

- ☐ 3 meals with healthy snacks
- ☐ 3 meals
- ☐ 2 meals or less
- ☐ Skip breakfast or other meals
- ☐ Generally eat on the run
- ☐ No regular eating pattern
- ☐ Often crave sweets/carbs
- ☐ Graze; small, frequent meals

(How many per day? _____)

Current level of exercise (Please check one that applies):

- ☐ None
- ☐ Light exercise (1-3 times per week, easy pace, stretching, walking, etc.)
- ☐ Moderate exercise (2-3 times per week, moderate pace, some weights, etc.)
- ☐ Heavy exercise: (3-4 times per week, vigorous pace, weights, fast running, etc.)

Do you eat because of emotions? ☐ Yes ☐ No

On an average day, please describe (in detail) your normal eating habits

Breakfast_____

Snack_____

Lunch_____

Snack_____

Dinner_____

Health History

Are you **Pregnant**? ☐Yes ☐No

Are you **Breastfeeding**? ☐Yes ☐No

Cancer:

Do you have Cancer? ☐Yes ☐No

Are you in Cancer remission? ☐Yes ☐No

Epilepsy:

Do you have Epilepsy? ☐Yes ☐No

Photosensitive:

Are you Photosensitive? ☐Yes ☐No

Liver Function:

Do you have liver problems? ☐Yes ☐No

If so, please specify _____

If so, are you under the care of a physician? ☐Yes ☐No

Are you taking medication? ☐Yes ☐No

If so, please list: _____

Diabetes:

Do you have diabetes? ☐Yes ☐No (skip this section)

If so, are you under care of a physician? ☐Yes ☐No

If so, which type?

☐ Type I ☐ Type II ☐ Insulin required (diabetes pills followed by insulin)

Is your blood sugar level monitored? ☐Yes ☐No

If so, by whom? ☐Myself ☐Physician ☐Other: specify _____

Are you taking any medication? ☐Yes ☐No

If so, please list: _____

Cardiovascular:

Do you have pacemaker? ☐Yes ☐No

Have you had a cardiovascular event? ☐Yes ☐No (skip this section)

If so, please specify: _____

How long ago? _____

If so, are you under the care of a physician? ☐Yes ☐No

Are you taking medication? ☐Yes ☐No

If so, please list: _____

Do you have hypertension (high blood pressure)? ☐Yes ☐No (skip this section)

If so, do you have your blood pressure checked? ☐Yes ☐No

If so, are you under the care car of a physician? ☐Yes ☐No

Are you taking medication? ☐Yes ☐No

If so, please list: _____

Digestive Function:

Do you have: ☐Irritable colon ☐Colitis ☐Diarrhea

☐Diverticulitis ☐Crohn's disease ☐Constipation

If so, are you under the care of a physician? ☐Yes ☐No

Are you taking medication? ☐Yes ☐No

If so, please list: _____

Stomach Function:

Do you have: ☐Acid reflux ☐Gastric ulcer ☐Heartburn

If so, are you under the care of a physician? ☐Yes ☐No

Are you taking medication? ☐Yes ☐No

If so, please list: _____

Thyroid Function:

Do you have thyroid problems? ☐Yes ☐No

If so, please specify _____

If so, are you under the care of a physician? ☐Yes ☐No

Are you taking medication? ☐Yes ☐No

If so, please list: _____

LIST ANY OTHER MEDICATIONS YOU ARE CURRENTLY TAKING, HEALTH CONCERNS YOU MAY HAVE, OR ANYTHING ELSE YOU THINK SHOULD BE KNOWN:

_____

_____

_____

Patient Signature: _____ Date: _____

Patient Printed Name: _____