Body Slender
LASER CENTER

CLIENT INFORMATION/INTAKE FORM

Name:	**Date of Birth:**	**Male/Female:**
Address:		
City:	**State:**	**Zip:**
Email:	**Cell Phone:**	**Occupation:**
Referred by (How did you hear about us?):		

MEDICAL HISTORY: Please check all that apply (if any)

I am over 18 years old and have proof of identification	☐ Yes	☐ No
I am Pregnant or Breastfeeding	☐ Yes	☐ No
I have cardiovascular disease or disorder (ex. Pacemaker or defibrillator)	☐ Yes	☐ No
I have liver disease	☐ Yes	☐ No
I have kidney disease	☐ Yes	☐ No
I have/had cancer, if in remission please indicate how long	☐ Yes	☐ No
I have a compromised immune system	☐ Yes	☐ No
I have disease or disordered stimulated by light (ex. Epilepsy)	☐ Yes	☐ No
I have retinal detachment	☐ Yes	☐ No
I have skin lesions	☐ Yes	☐ No
I have thyroid gland dysfunctions	☐ Yes	☐ No
I have photosensitivity to sun exposure	☐ Yes	☐ No
I am taking medications which cause photo sensitivity	☐Yes	☐ No
I have gastrointestinal issues (ex. IBS, Crohn's)	☐ Yes	☐ No
I have regular bowel movements	☐ Yes	☐ No
Are you cleared to exercise?	☐ Yes	☐ No
Do you have any aches, pains or injuries we should be aware of before your workout? If yes please list here	☐ Yes	☐ No

PHOTOGRAPHY

☐ I consent to taking before and after photographs and authorize their ANONYMOUS use for the purpose of medical audit, education, and/or promotion. Initial Here:

ACKNOWLEDGEMENT

☐ I understand that there are no guarantees to the results of this treatment. I understand to achieve maximum results, I may require several treatments

☐It has also been recommended to achieve optimum results, I understand that an appropriate diet and regular exercise will assist to sustain and create a cumulative degree of overall fat reduction and body contouring.

☐I have been informed and understand that temporary hyper-pigmentation/hypo-pigmentation on rare occasion may occur as a result of treatment.

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☐ I understand that there is a 24 hour cancellation policy for all appointments. Any no show or late cancellation/reschedule will be counted against my pre-paid sessions.
☐ I understand that Lipo Laser is for the treatment of musculoskeletal conditions, inch loss has been found to be a benefit.

Medication Name: **Dosage:** **Date Started:** **Used for:**

_____
_____
_____

Supplements:

_____
_____

List Use of Qty (☐ Daily/ ☐ Weekly/ ☐ Monthly/ ☐ Occasionally):

Tobacco: ☐ Y/ ☐ N _____ Amount: _____
Alcohol: ☐ Y/ ☐ N _____ Amount: _____
Caffeine: ☐ Y/ ☐ N _____ Amount: _____

Have you ever seen a Chiropractor before? (Yes/No)

Have you done diet programs before? (☐ Yes/☐ No) If yes, which ones:

_____

General symptoms (please check any of the following you have experienced in the last 6 months):

☐ Headache
☐ Neck pain
☐ Sleep problems
☐ Upper back pain
☐ Nervousness
☐ Tension
☐ Irritability
☐ Chest pain
☐ Dizziness
☐ Face flush
☐ Low back pain
☐ Stiff neck
☐ Digestive issues
☐ Hip pain
☐ Pins & Needles (legs/ feet)
☐ Pins & Needles (arms/ hands)
☐ Numbness (fingers/ feet)
☐ Shortness of breath
☐ Fatigue
☐ Depression
☐ Light bothers eyes
☐ Loss of memory
☐ Ears ringing
☐ Fever
☐ Loss of balance
☐ Weight trouble
☐ Knee pain
☐ Other: _____
☐ Shoulder pain
☐ Fainting
☐ Loss of smell
☐ Loss of taste
☐ Diarrhea
☐ Cold feet
☐ Cold hands
☐ Upset stomach
☐ Constipation
☐ Cold sweats
☐ Alcohol/ drug problem
☐ Allergies
☐ Eating disorder

I also confirm that the answers to the questionnaire are true and correct to the best of my knowledge. I also confirm the staff explained the treatment(s) and answered my questions.

_____ _____
Client Signature Date