KANSAS CITY®
LASER-LIKE LIPO

New Client Weight Loss Intake Form

Personal Information

Date ____ / ____ / _____

First Name _____ Last Name _____

Address _____

City _____ State _____ Zip Code _____

Cell Phone _____ Home Phone_____

Email Address_____

Date of Birth _____/_____/_____ Sex: Male Female Other _____

Age _____ Height _____ Weight _____

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Occupation _____ Hobby_____

How did you hear about us? _____

Emergency Contact Information

First Name _____ Last Name _____

Cell Phone _____ Home Phone_____

Email Address_____ Relationship_____

Health and Wellness History

Please select below all that apply as a current or previous condition:

- ☐ Lupus
- ☐ PCOS
- ☐ Vitiligo
- ☐ Seizures
- ☐ Epilepsy
- ☐ GI Issues
- ☐ Open lesions
- ☐ Gastric Sleeve
- ☐ Active Herpes
- ☐ Thyroid Issues
- ☐ Heart Condition
- ☐ Thrombophlebitis
- ☐ Dilated capillaries
- ☐ Glandular swelling
- ☐ Undiagnosed lumps
- ☐ Pregnancy/lactating
- ☐ Diabetes Type 1 & 2
- ☐ Implant contraceptive
- ☐ Keloid scar formation
- ☐ Anticoagulant Therapy
- ☐ Liver/Kidney Disorders
- ☐ Metal or mesh implants
- ☐ Cardiovascular disorders
- ☐ Current Outbreak of Hives
- ☐ Accutane or acne medications
- ☐ Hypotension & Hypertension
- ☐ Surgery in the last three months
- ☐ Botox within the past two weeks
- ☐ Subcutaneous Hormone Pellets (HRT)
- ☐ PDO Threads within the last 4 months
- ☐ Fillers received within the last 4 weeks
- ☐ Varicose veins in desired treatment area
- ☐ Skin diseases or abnormal wound healing
- ☐ Sensitivity to light or consuming photosensitive medications
- ☐ Active Implanted devices (pacemaker, urethral stimulator or internal defibrillator)
- ☐ Active Cancer or Cancer treatments in the past five years (unless doctor's clearance is received)

Please mention any conditions not listed above, which may affect your skin/body during treatment

_____

_____

_____

_____

Who is your physician? _____

Are you currently taking any medications? □ Yes □ No (If yes, please list them on the medication page)

Has your doctor advised you to lose weight? _____

Do you have any dietary restrictions? □ Yes □ No (If yes, please explain) _____

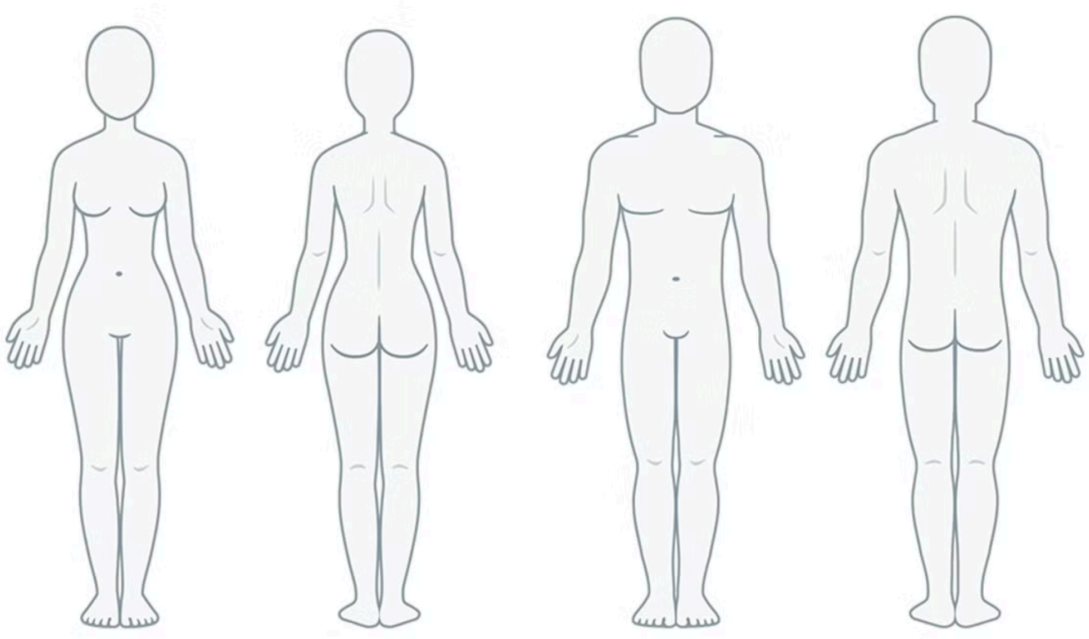
How often do you exercise? _____ What type of exercise?_____

Do you feel stressed? □ Yes □ No

(If yes, please explain) _____

Please answer the following questions honestly!!
We want to do our best to help you reach your goals.

Circle the area(s) of your body you are looking to improve.



When was the last time you were at your goal weight? _____

What do you consider to be your ideal weight? _____

How much weight do you want to lose? _____

How many times a year do you diet? _____

What is stopping you from losing weight on your own? _____

What have you tried in the past that has failed? _____

Does your weight problem make you physically uncomfortable? □ Yes □ No

Please describe:_____

Does your weight problem cause physical pain? □ Yes □ No

Please describe:_____

Are you embarrassed by your excessive weight? □ Yes □ No

Please describe:_____

Does being overweight and unhealthy limit your activities?	□ Yes	□ No
Do you binge eat?	□ Yes	□ No
Do you suffer from uncontrollable cravings?	□ Yes	□ No
Do you feel that food controls you?	□ Yes	□ No
Do you eat because of your emotions?	□ Yes	□ No
Do you eat between meals?	□ Yes	□ No

What do you choose to eat between meals? _____

Briefly describe your daily eating behaviors: _____

_____

Does being overweight and unhealthy limit your activities? □ Yes □ No

Do you feel that your eating behaviors are normal? □ Yes □ No

Do you feel tired, run down, or out of energy? □ Yes □ No

Is successful weight loss a top priority? □ Yes □ No

How fast do you want to be slim, trim, and fit? _____

What's more important to you: Fast? Permanent?

Does your family support your weight loss efforts? □ Yes □ No

Is your family excited that you´re working with us? □ Yes □ No

Can you remember being at your ideal weight? □ Yes □ No

What do you remember most about it? _____

Circle ALL areas of treatment that interest you:

Weight Loss	Cleansing and Detoxification	General Wellness
More Energy	Stress Reduction	Fat Reduction
Cellulite Reduction	Skin Tighting	Other _____

What is the most important element in deciding to use our services?

Circle only <u>ONE</u> of the four answers:

EFFECTIVENESS	”My results are my top priority.”
TIME	”I want results quickly.”
SERVICE	”I need extra support along the way.”
AFFORDABILITY	”I need it to be affordable.”

PLEASE LIST ALL MEDICATIONS

(This includes prescription, over the counter drugs and supplements)

Medication name: **Dosage:** **Frequency:**

_____

_____

_____

_____

_____

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I understand that my entire patient history will remain completely confidential and will not be released without express written consent from me.

Signature: _____ Date:_____

LIABILITY RELEASE

This client has requested services for Photobiomodulation treatments and Hypervibration session(s).

Photobiomodulation treatments penetrate through the skin, stimulating the transitory pores of the fat cell to open up and the fat cell can expel stored contents resulting in a decrease in fat cell size and supporting weight loss. Hypervibration stimulates lymphatic drainage, muscle contraction, metabolism and energy burning. As such, we require a statement to ensure that there are no known medical contraindications before proceeding with any treatment sessions.

The following are known contraindications to Photobiomodulation:

Pregnant or may be pregnant
Nursing
Fever
Alcohol/alcohol abuse
Certain medications that may cause photosensitivity
Epilepsy
Currently undergoing chemotherapy
Pacemaker/defibrillator
Photosensitivity
Recent fracture
Any other condition that should be disclosed and listed on the intake form

I understand that I may experience a mild to moderate warmth from the light on the skin, intense warmth/heat is not normal, and you should notify a staff member immediately and the light paddle will be inspected for proper placement or defect.

Because Photobiomodulation treatment should not be used under certain medical conditions, I affirm that I have stated all of my known medical conditions, and answered all questions honestly. I agree to keep the staff updated as to any changes in my medical profile before the session and understand that there shall be no accountability on the staff's part should I fail to do so.

By signing this form, I give Kansas City Laser-Like Lipo consent to provide me with Photobiomodulation treatments and Hypervibration sessions and release them from all liability.

Further, I agree to the above statements and agree that there are no contraindications.

Client Signature _____ **Date** _____

Clinic Staff Signature _____ **Date** _____

PATIENT CONSIDERATIONS

Most can use red light therapy treatments, but there are some special considerations;

- Persons diagnosed with active basal cell carcinoma
- Women who are pregnant should consult their physician before beginning red/NIR light therapy treatments.
- Clients with Epilepsy should consult their physician before beginning red/NIR light therapy treatments.
- Taking medications that cause sensitivity to light (example: tetracycline)

The following medicines are known to cause temporary photosensitivity:
Please carefully look over the following list of medications and check off any you have taken in the past 7 days. These medications have been known to cause light sensitivity.

Anti-Arrhythmic Amiodarone (Pacerone® Cordarone® Aratac®)
Chlorpromazine (Thorazine®, Chloramead®, Chlordryprom®, Chlor® Promanyl®, Largactil®, Promapar®, Promosol®, Terpium®, Sonazine®)
Acne Oral Isotretinoin (Accutane®, Accure®, Aknenormin®, Amnesteem®, Ciscutan®, Claravis®, Isohexal®, Isotroin®, Oratane®, Sotret®, Roaccutane®)
Topical Isotretinoin (Isotrex®, Isotrexin®)
Anti-Psychotic Haloperidol (Haldol®)
Trifluoperazine (Stelazine®, Clnazine®, Novoflurazine®, Pentazine®, Solazine®, Terfluzine®, Triflurin®, Tripazine®)
Anti-Fungal Griseofulvin (Grifulvin®)
Antibiotics Tetracycline (Helidac®, Terra-Cortril®, Terramycin®, Sumycin®, Actisite®, Bristacycline®, Actisite®, Tetrex®, Doxycycline®, Ciprofloxacin®)
Norfloxacin (Noroxin®, Quinabic®, Janacin®)
Ofloxacin (floxin®, Oxaldin®, Tarivid®)
Nalidixic acid (NegGam®, Wintomylon®)
Ciprofloxacin (Cipro®, Ciproxin®, Ciprobay®)
Minocycline (Minomycin®, Minocin®, Arestin®, Akamin®, Aknemin®, Solodyn®, Dynacin®, Sebomin®)
Oxytetracycline
Demeclocycline
Lymecycline
Cancer Methotrexate (MTX®, Aminopterin®, Ledertrexate®)
Arthritis Auranofin (Ridaura®)

The above drugs are currently the most common medications associated with photosensitivity and are by no means a complete list of all photosensitive medications. Herbs and over the counter medications such as psoralen and St. John's Wort can also cause sensitivity to light, so it is important to disclose any and all medications or herbs you are currently taking.

Signature: _____ Date: _____

Print Name:_____

Witness (Employee) Signature: _____ Date: _____