New Patient Weight Loss Intake Form

Basic Patient Information

Name:			Date:	
Street Address:				
City:		State:		Zip:
Home Phone:		Cell Phone:		
Email Address:				
Sex: M F	Age:	Birth date:	Height:	Weight:
Marital Status: □ Single	□ Married	□ Widowed	□ Separated	□ Divorced
Occupation:		Hobby:		
How did you hear about us?				

Health and Wellness History

Are you currently under the care of a physician?
Are you taking any medications? **(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 Explain:
Check ALL that apply to you: □ Pregnant/Might Be Pregnant □ Heart Condition □ Gallbladder Removal □ Epilepsy/Seizures □ Currently Undergoing Chemo □ Breast Feeding □ Gastric Sleeve □ GI Issues □ Thyroid Issues □ PCOS □ Photosensitivity □ Diabetes: Type 1 Type 2

Please answer the following questions honestly so we can do our best to help you reach your goals.

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:
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 or 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?

Have you ever used any of the below treatments before? □ Yes □ No

Check ALL areas of treatment that interest you:

□ Weight Loss □ Cleansing and Detoxification □ General Wellness □ Body Wraps □ More Energy □ Stress Reduction □ Other

Did you know that all treatments above are 100% safe?

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

Circle only ONE 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.”

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

Signature: _____ Date:_____

(Please see reverse side)

PLEASE LIST ALL MEDICATIONS

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

Medication name: Dosage: Frequency:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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** _____

Missed Appointment Policy

Our goal is to provide quality, individualized services in a timely manner. No-shows, late shows, and late cancellations inconvenience those individuals who need access to our services. We would like to bring your attention to our policy regarding “Missed” appointments.

Late Shows

In order to respect the time of all clients scheduled and to provide the best service we can, weight loss clients who are 10 minutes late or more for their appointment will be considered as **“Missed”**.

Cancellation of an Appointment

In order to be respectful of the needs of other clients, please be courteous and call our office promptly if you are unable to show up for an appointment. We require that you call at least 48 hours in advance. Appointments are in high demand and your early cancellation will allow another client access to timely services. We understand last minute emergencies do come up, so please call our office to let us know your situation. If we do not hear from you, the appointment will be considered a “No-Show” and will automatically be considered a **“Missed”** appointment that can not be rescheduled.

How to Cancel Your Appointment

To cancel your appointment, please call the office at (913) 764-9393 within 48 hours. If you do not reach a staff member, you may leave a detailed message with our answering service. We will return your call as soon as possible and try to get your appointment rescheduled.

Late Cancellations

A cancellation is considered to be “Late” when the appointment is canceled without 48 hour advance notice. A “Late cancellation” will result in the appointment being **“Missed”**.

Missed Appointment Policy

Failure to be present at the time of a scheduled appointment will be recorded in the client’s chart as **“Missed”**. This includes arriving 10 minutes late after your scheduled appointment. The first time there is a “Late Arrival”, “No-Show” or “Late cancellation”, there will be no charge to the client. A Second occurrence will result in a **$20** fee automatically charged to your credit card on file. As well as, a **$20** charge to future appointments that are missed due to “Late Arrival”, “No-Show”, or “Late cancellations”. If you find that you are unable to make future appointments due to unexpected circumstances, please let us know and we will be happy to put your program on hold so that you do not lose any of your future appointments. We will reschedule them for you at a later date when you are ready to resume your program.

Printed Name_____ **Date**_____

Signature_____

MAX MIRACLE/MEDWAVE CLIENT RELEASE AND INFORMED CONSENT

PLEASE READ THE FOLLOWING INFORMATION AND ACKNOWLEDGE THAT YOU UNDERSTAND AND ACCEPT ALL PROVISIONS BY SIGNING BELOW.

It is our intention to keep you as well informed about using the Max Miracle and MedWave as possible. This means informing you how to operate the Max Miracle and MedWave treatments. The proper procedure to follow in the treatment room will be clearly explained by a member of our staff. Please feel free to ask any questions.

1. START OUT AT A SHORTER TREATMENT TIME, Humans come in a vast array of colors and sizes. It is what makes us a unique species and because of this variety in humanity, red light therapy cannot be a “one size fits all” approach. _____ (initial)

2. CERTAIN MEDICATIONS, Medications and certain lotions may cause your skin to be more sensitive to photobiomodulation. Check the posted list of drugs and products known to increase the photosensitivity of the skin. Check with your physician or pharmacist if you are unsure about any medications you are taking or if you have had a problem with skin sensitivity in the past. _____ (initial)

3. WEAR PROTECTIVE EYEWEAR, Please wear protective eyewear during your treatment. Protective eyewear is available in the treatment room. _____ (initial)

4. UNDERGARMENTS, Wear light colored, metal-free clothing and remove all jewelry. Dark colored clothing heats up faster and can become uncomfortable. _____ (initial)

5. TATTOOS, If a patient has a dark-colored tattoo, it can get hot, and we recommend covering it with a light- colored cloth (white is best) or bandage. You can even cut white nylons from the drugstore for the arm and hand hole to cover the sleeve. This will allow some of the light to penetrate the thin nylon layer, and the patient won’t get too hot. ***** KC Laser Like Lipo does not provide bandages or nylon sleeves. This is the client’s own responsibility.** _____ (initial)

6. Frequent use of RETINOL can cause photosensitivity. You will be responsible for covering any area that may increase the photosensitivity of the skin. _____ (initial)

7. I am 18 years or older. _____ (initial)

I have read the contents of this consent form carefully and state that I am not aware of any medical condition or other reason that would prohibit me from using the Max MIracle or MedWave machines. I understand that I will not be allowed to exceed the maximum allowable time posted on this device. I have been given adequate instructions for the proper use of this equipment, understand the risks involved, and use it at my own risk. I hereby agree to release the owners, operators and manufacturers from any damages that I might incur due to the use of this facility.

Signature: _____ Date: _____

Print Name:_____

Witness (Employee) 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: _____