



KANSAS CITY®
LASER-LIKE LIPO

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

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? _____

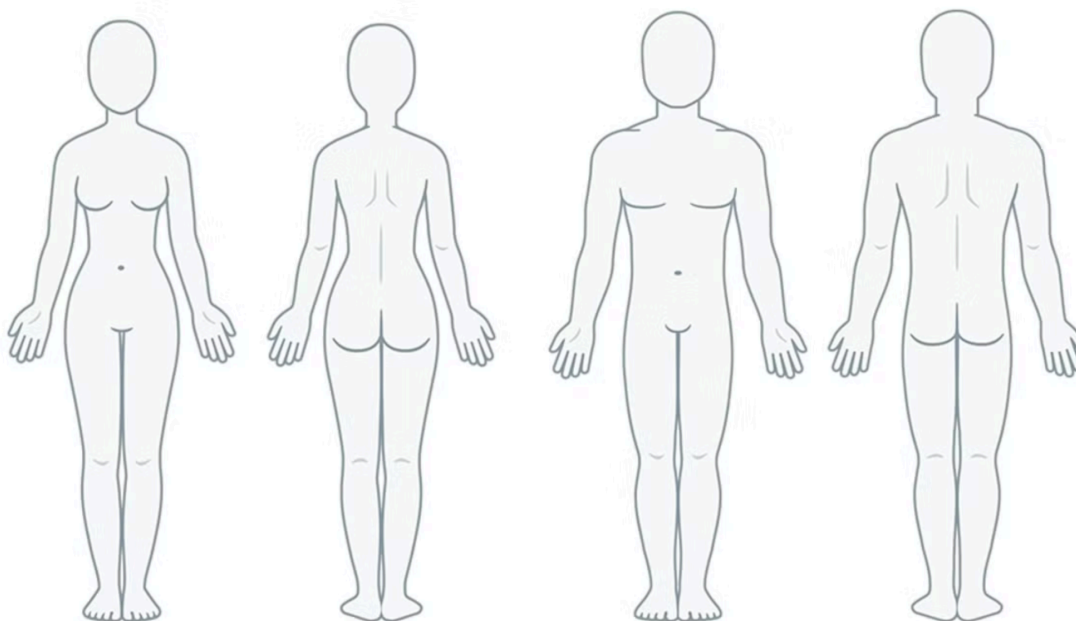
What type of exercise? _____

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? _____ ☐ N/A

What do you consider to be your ideal weight? _____ ☐ N/A

How much weight do you want to lose? _____ ☐ N/A

How many times a year do you diet? _____ ☐ N/A

What is stopping you from losing weight on your own? _____ ☐ N/A

What have you tried in the past that has failed? _____ ☐ N/A

Does your weight problem make you physically uncomfortable? ☐ Yes ☐ No ☐ N/A

Please describe: _____

Does your weight problem cause physical pain? ☐ Yes ☐ No ☐ N/A

Please describe: _____

Are you embarrassed by your excessive weight? ☐ Yes ☐ No ☐ N/A

Please describe: _____

Does being overweight and unhealthy limit your activities? ☐ Yes ☐ No ☐ N/A

Do you binge eat? ☐ Yes ☐ No ☐ N/A

Do you suffer from uncontrollable cravings? ☐ Yes ☐ No ☐ N/A

Do you feel that food controls you? ☐ Yes ☐ No ☐ N/A

Do you eat because of your emotions? ☐ Yes ☐ No ☐ N/A

Do you eat between meals? ☐ Yes ☐ No ☐ N/A

What do you choose to eat between meals? _____ ☐ N/A

Briefly describe your daily eating behaviors: _____

Does being overweight and unhealthy limit your activities? ☐ Yes ☐ No ☐ N/A

Do you feel that your eating behaviors are normal? ☐ Yes ☐ No ☐ N/A

Do you feel tired, run down, or out of energy? ☐ Yes ☐ No ☐ N/A

Is successful weight loss a top priority? ☐ Yes ☐ No ☐ N/A

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 ☐ N/A

Is your family excited that you're working with us? ☐ Yes ☐ No ☐ N/A

Can you remember being at your ideal weight? ☐ Yes ☐ No ☐ N/A

What do you remember most about it? _____ ☐ N/A

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 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."

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

Frequency:

[illegible]

Signature: _____ **Date:** _____



Client Consent, Assumption of Risk & Release

16041 South Bradley Drive, Olathe, KS (913) 764 - 9393 www.kclaserlikelipo.com

Please read this form, check any health items that apply to you, and sign at the end. One signature covers every service you receive with us, now and in the future.

Client Information

Full Name _____ Date of Birth ____/____/____

Phone Number _____ Email Address _____

In this form, “we,” “us,” and “the Company” mean Kansas City Laser-Like Lipo (Olathe Chiropractic LLC). “I” and “me” mean the client signing below. “Services” means any service listed below, plus use of our equipment and facilities.

Our Services and Their Possible Side Effects

These services are generally well tolerated. Side effects, when they happen, are usually mild and short-lived. Tell staff right away if anything feels wrong during a session.

Service	What it is	Possible side effects
Laser body contouring	Low-level laser light applied over target areas	Temporary warmth, mild redness, thirst, more frequent urination
Sauna	Heat therapy session	Overheating, dehydration, dizziness or fainting, low blood pressure, skin irritation
EWOT (Exercise With Oxygen Therapy)	Exercise while breathing concentrated oxygen through a mask	Shortness of breath, lightheadedness, dry nose or throat
Whole body vibration	Standing or exercising on a vibrating platform	Dizziness, nausea, muscle soreness, joint discomfort, itching in the legs
T-Shape 2	Device sessions using heat, radiofrequency, and massage on target areas	Warmth, redness, tenderness, mild swelling or bruising, rare burns or skin irritation

No results are guaranteed. Results vary from person to person and depend on factors like diet, activity, hydration, and following our recommendations.

Health Screening

Check every item that applies to you. A checked box does not always mean you cannot receive services; our team will review it with you and may ask for written clearance from your doctor.

Section A: Some of our services may be contraindicated, check if any of these apply

- | | |
|--|---|
| ☐ Pregnant, possibly pregnant, or breastfeeding | ☐ Seizure disorder or epilepsy |
| ☐ Active cancer (unless cleared by your doctor) | ☐ Cancer treatment in the past 5 years |
| ☐ Blood clots or thrombophlebitis | ☐ Open wounds, sores, or lesions in the area to be treated |
| ☐ Pacemaker, internal defibrillator, or other implanted electronic device | ☐ Recent surgery (past 3 months), or surgery in the area to be treated (past 3 months) |
| ☐ N/A | |

Section B: Check all that apply

- | | |
|---|---|
| ☐ Heart or cardiovascular condition | ☐ Taking medication that causes sensitivity to light or heat |
| ☐ High or low blood pressure | ☐ Hormone pellets (HRT); we will avoid the insertion site |
| ☐ Diabetes (type 1 or 2) | ☐ Unexplained lumps |
| ☐ Liver or kidney disorder | ☐ History of keloid scarring |
| ☐ Autoimmune condition (including lupus) | ☐ Metal or mesh implants |
| ☐ Lung or breathing condition (asthma, COPD) | ☐ Taking blood thinners |
| ☐ N/A | |

Other: _____

Section C: Check all that apply

Laser and T-Shape 2 (treatment area only)

- | | |
|--|--|
| ☐ Accutane, or acne medication (oral or topical) | ☐ Swollen glands |
| ☐ Varicose veins, dilated capillaries, or skin disease (vitiligo, active hives, active herpes/cold sores) | ☐ Nexplanon birth control implant (if treating the arms) |
| ☐ Fillers in the past 4 weeks, Botox in the past 2 weeks, or PDO threads in the past 4 months | ☐ Piercings or metal on the skin (must be removed before treatment) |
| ☐ N/A | |

Sauna

- | | |
|--|---|
| ☐ Heat sensitivity, or history of heat exhaustion or fainting | ☐ Alcohol in the past 24 hours |
| ☐ N/A | |

EWOT (Exercise with Oxygen Therapy)

- | | |
|---|--|
| ☐ Lung condition, or history of collapsed lung | ☐ Unable to exercise safely (ask staff if unsure) |
| ☐ N/A | |

Whole body vibration

- | | |
|---|--|
| ☐ Recent fracture, or osteoporosis | ☐ Inner ear or balance disorder |
| ☐ Herniated disc or recent back injury | ☐ Gallstones or kidney stones |
| ☐ N/A | |

Notes for Staff (Anything checked above): _____

What I Understand and Agree To

By signing, I agree to each of the following:

- 1. I am choosing these services voluntarily.** I understand they carry some risk, including the side effects listed above, and I accept those risks.
- 2. These are wellness services, not medical care.** They are not meant to diagnose, treat, or cure any disease. They do not replace care from my own doctor.
- 3. No results are promised.** No one has guaranteed me any specific result, and I am not relying on any such promise.
- 4. My health information is accurate.** I have answered the health screening honestly. I will tell staff right away if my health, medications, or pregnancy status changes.
- 5. I have not been told by a doctor to avoid these or similar services.**
- 6. I am clear-headed today.** I am not under the influence of alcohol, drugs, or any medication that impairs my judgment.
- 7. I will follow the rules.** I will follow posted safety signs, rules, and staff instructions at all times.
- 8. Staff may pause or decline services.** If staff believe a service could put me at risk, they may decline it until I provide written clearance from my doctor, at my own expense.
- 9. I am responsible for my own outcomes.** I accept full responsibility for any injury or damage I experience, or that is made worse, in connection with the services.
- 10. I release the Company from claims.** To the fullest extent allowed by law, I release and hold harmless Kansas City Laser Like Lipo, its owners, employees, contractors, and affiliates, and the makers and distributors of its equipment, from any claims, costs, or damages related to the services. This applies to me and to my heirs and representatives.

Photos and Personal Belongings

Photos and video. I may be photographed or recorded for safety, progress tracking, training, and marketing. I consent to this use without payment, and the Company owns those images.

Personal belongings. I have been advised not to bring valuables. The Company is not responsible for lost, stolen, or damaged personal items, including items left in the building which includes; sauna, treatment rooms and restrooms.

Signature

I HAVE READ THIS FORM AND UNDERSTAND IT. I KNOW I AM GIVING UP CERTAIN LEGAL RIGHTS, INCLUDING MY RIGHT TO SUE THE COMPANY IN SOME SITUATIONS. I AM SIGNING FREELY AND VOLUNTARILY. THIS AGREEMENT HAS NO END DATE AND COVERS ALL FUTURE VISITS.

Client Signature: _____ Date: _____

Printed Name: _____

(OFFICE USE ONLY)

Reviewed by (staff): _____ Date: _____

Doctor clearance required? ☐ Yes ☐ No Clearance received (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, 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.

Client Signature: _____

Date: _____

Printed Name: _____