Light Body Sculpting

New Patient Weight Loss and Body Contouring Intake Form

Treatment _____ Date_____
Groupon Voucher #_____
Website Coupon_____ } Please enjoy 1 per Customer!

Name_____
Address_____ City_____ State_____ Zip_____
Cell # _____May we text you?_____
Email _____ **Single Married Divorced Widowed**
Age_____Gender _____Date of Birth_____
Occupation _____ Do you sit at a computer all day? _____

Have you ever been diagnosed with:

Epilepsy____	Hiatal Hernia_____	Liver Disease_____	Heart Disease_____
Thyroid____	Adrenal Fatigue___	Kidney Disease____	Heart Arrhythmia____
Cancer_____	Auto Immune Dx_____	High Blood Pressure____	Ankle Swelling/Edema____
Diabetes___	Family Diabetes_____	Allergic to Niacin_____	Allergic to Aloe____
		Hysterectomy_____	Gall Bladder Removed_____

Are you :
Pregnant?_____ Breast Feeding?_____Under the care of a Physician?_____ For:_____
Do you experience **daily chronic pain from any condition**?_____

Lifestyle :
Do you exercise?_____Do you smoke?_____Do you sleep well at night?_____How many hours_____
High Stress Daily?_____ Are you experiencing hair loss or thinning? _____
How much water do you drink daily?_____ Do you drink Soda Alcohol Wine Beer
Please circle all stressors that apply to you: Anger Worry Sadness Depression Overwhelmed
Work Relationships Finances

Your Goals:

I want to lose_____#pounds **Current Height_____Current Weight _____**
I want to lose _____pants or dress sizes Your ideal weight_____

Areas of Concern: **Abdomen Thighs Hips Arms Back Chin Other**_____
Cellulite Reduction? _____

Do you want your weight loss to be Fast____ Permanent____ Both_____ By when_____
Special event coming up? **Anniv. Vacation Wedding Reunion B-Day Date_____**

What are the top 3 questions you have for the Doctor regarding your treatment?
1. _____
2._____
3._____

What would you say are your top 3 contributing factors to your weight?

Low Energy/Fatigue	Your Age	Other_____
Hormonal Changes	No Exercise	Other_____
Injury - Sedentary lifestyle	Not Enough Sleep	Other_____
Hereditary Factors	Your Mindset	
Poor Eating Habits	Wine/Alcohol	
Haven't made it a Priority	Traumatic Life Event	

Has your weight been an emotional strain for you? **Yes** **No**
What have you done so far to achieve your goals?_____
Does your family support your weight loss efforts?_____ Do they know you're here? _____

Rate your commitment level to your weight loss results (1-100%) _____ %
What specific food or drink are you **not willing** to give up?_____
What cravings do you experience? Choc Sugar Bread Pasta Soda Chips Other_____

Check ALL areas of treatment that interest you!

____Weight Loss ____Cleansing & Detoxification ____More Energy ____Body Contouring/Inch Loss
____Stress Reduction ____Burn 900-1400cal per Wrap Treatment ____Insomnia ____Quit Smoking
____Reduce Cellulite ____Fitness ____Memory & Mood ____Skincare ____Hormone Balance

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

EFFECTIVENESS:	"My results are my top priority"
TIME:	"I want results quickly"
SERVICE:	"I need extra support along the way"
AFFORDABILITY:	"I need this to be affordable"

Appointment Policies: Please initial next to each:
_____Please treat appointments like massage appts. You have rented the room for a specific time. Arriving late may not guarantee your appt.
_____No show fee $45
_____Last minute cancellation fee: $45 (5 hour window, within business hours)

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

Signature:_____ Date:_____

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Thank you for your interest in Light Body Sculpting!
We know you have a choice of businesses and are certainly glad you chose us!