Patient Name: ____ Date: ______________

Address: ____ City: ___________ St: ______ Zip: _____________

Email Address: ____ Ok to send email: Yes No

Phone: ________________ Date Of Birth: ________________ Age: _______

Occupation: ____

Single – Married – Divorced – Widowed

Height___________ Current Weight/BMI________________ Goal Weight/BMI_________________

Are you currently pregnant or breast feeding? Yes No (***If yes, you are not eligible to participate in this program)***

Possible Contraindications

Please check (√) all symptoms you have ever had, even if they do not seem related to your current problem:

___ Active Cancer ___ Thyroid Problems ___ Pacemaker

___ Photo Sensitive ___ Liver Problems ___ Kidney Problems

___ Epilepsy ___ Minor ___ Cholecystitis

General History

Do you experience any of the following conditions even if they are minor and go away on their own?

___ High Blood Pressure	___ Diabetes	___ Headaches	___ Hypoglycemia
___ Cancer	___ Neck Pain	___ Back Pain	___ Thyroid Problems
___ Heart Disease	___ Digestive Problems	___ Arthritis	___ Chronic Fatigue
___ Fibromyalgia	___ Numbness	___ Stress/Irritability	___ Sinus/Allergy
___ Hip/Knee Pain	___ Osteoporosis	___ Chronic Inflammation	___ Pins & Needles
___ Dizziness	___ Sleeping Problems	___ Cold Sweats	___ Loss of smell
___ Buzzing in ears	___ Depression	___ Stiff Neck	___ Lights bother eyes
___ Fainting	___ Ringing in ears	___ Loss of taste	___ Irritability
___ Cold Hands/Feet	___ Fever	___ Urinary Problems	___ Loss of balance
___ Nervousness	___ Stomach Upset	___ Heartburn	___ Hot Flashes
___ Tension	___ Other:		

Please list any drugs you are taking and why? (Prescription and non-prescription, please let us know if you have been on antibiotics or steroids in the last 2 weeks)

____

____

Do you currently take nutritional supplementation? **(If "yes" is the patient taking essential fatty acids? They will need to discontinue EFA's while on the program)**

Have you had any surgery? (Please include all surgeries)

1. Type ____ Date ________________ Dr. __________________

2. Type ____ Date ________________ Dr. __________________

3. Type ____ Date ________________ Dr. __________________

Other Health Concerns (if any):

List of Health Concerns	Rate of Severity, 1= Mild 10=Worst	When did this episode start	If you had the condition before, when	Did problem begin with an injury	Are your symptoms constant/intermittent

Your Health and Weight Loss Profile: Why This Form Is Important

We focus on your ability to be well. Our goals are to first address the issues that brought you to this office and second, to offer you the opportunity of improved health, wellness and quality of life in the future. On a daily basis we all experience physical, biochemical and psychological/emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual and may not even be felt until they become serious. Answering the following questions will give us a profile of specific stresses past and present that you face and allow us to better asses the challenges to your health potential.

Do you currently want to lose weight, inches or both?

How much weight or inches do you want to lose? Where?

How long have you struggled with your weight?

What are your main concerns?

Do you see your health/weight loss as an investment or an expense?

Do you have an upcoming event that you're preparing for?

Do you have a specific date you want to lose your weight/inches by?

Why do you want to lose weight/inches now? Why not wait till January?

Why do you want to do this with us? Why not just join a gym?

Have you tried to lose weight before? How many pounds did you lose?

What makes it better?

What makes it worse?

What all have you done that was of no help to lose the weight/fat?

What were your results? How long did you keep the weight off?

Is this or other conditions interfering with your:

□ Work □ Leisure □ Sleep □ Hobbies

□ Positive Mental Attitude □ Sports □ Exercise □ Walking □ Energy □ Family

Other: ____

Have you had to, or feel you may need to make any positive changes in your life due to your condition? (I.e. eat better, less alcohol or drugs, skipping meals, eating less, activity, exercise, refined carbs, etc.) If so, what? __________________
____

Please list your top three (or more) stresses in each category:

1. Physical stress (falls, accidents, work postures, etc.)
   a. ____
   b. ____
   c. ____
2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs, etc.)
   a. ____
   b. ____
   c. ____

3. Psychological stress (work, relationships, finances, self-esteem, etc.)
    a. ____
    b. ____
    c. ____

On a scale of 1-10 (1=none, 10=extreme) describe your psychological/emotional stress levels:

Personal level: _______________ Occupational Level: ________________ Other: _________________

On a scale of 1-10 (1=very poor, 10=excellent) describe your:

Eating Habits: _____________ Exercise Habits: _____________ Sleep: _____________

General Health: _____________ Mind-set: _____________ Mental Exercise: _____________

Do you have any other health challenges that you feel is important for us to know about?

Signature: ____ Date: ________________

Thanks for choosing Taylor Chiropractic and Weight Loss Clinic to help you reach your goals. We hope you will enjoy our lipo laser procedure as much as we enjoy serving you. In an effort to be sure that there are no misunderstandings about our lipo laser procedures we have put together some office polices that will ensure great results. Please read them carefully. They are binding and you are responsible for following these simple guidelines to redeem your Facebook/Groupon Coupons.

1. You are asked to eat lightly, drink lots of water and refrain from alcoholic beverages the day before your scheduled appointment.

2. No food at all 2 hours before your scheduled appointment.

3. No food at all 2 hours after your scheduled appointment.

4. Plan on some mild exercise like walking, swimming or cardio following your laser appointment. This will give you better results following the laser treatment.

5. Please arrive to this office 15 minutes prior to your scheduled appointment to ensure you receive the full time for your session. This visit cannot be made up. This is because of the strict time constraints that are part of the laser procedures. You're arriving late will push back the entire schedule and cannot be allowed. So PLEASE be here on time.

6. We have a strict “use or lose” policy due to scheduling constraints and the high demand for this service. **Only 1 cancelation will be accepted and missed appointments will be unable to be rescheduled under any circumstance**.

7. All visits must be scheduled within two weeks of the start date, unless the doctor or staff approves.

8. You are aware that these visits are **NOT** our usual plan and to get the lasting results as seen on our before and after pictures at the clinic and online it does require additional visits. **We do not offer refunds.** However, if you purchase a larger package, and for some reason have not lost 2 inches we will give you more treatments until you do.

9. Don't assume that everyone you meet at the office is a Stripe/Groupon client. You are asked to not discuss with any other customers while at the office about your fees or any other services being offered to you.

Please be patient and flexible with scheduling. We are trying to give each and every person the same experience as our regular customers. We wish you luck and hope you have a "WOW" this really works as so many have before you.

We will only allow the use of one discounted source. If you use the Facebook app we will not honor a Groupon purchase and vice versa.

I understand and agree to the above policies and procedures in conjunction with my lipo laser treatments here at Taylor Chiropractic and Weight Loss Clinic.

_________________________________ _______________________

Signature Date