Weight Loss

blueprint to Weight Loss

PERSONAL INFORMATION

Name _____ **Date** _____

Address _____

City _____ **State** _____ **Zip** _____

Phone *(Home)* _____ *Mobile* _____

Email _____ **Date of Birth** _____

Age _____ **Height** _____ **Occupation** _____

Who may we thank for referring you to our office?

Friend or Family _____ **Health Care Provider** _____

Online Search _____ **Wellness Class** _____ **Other** _____

MEDICAL HISTORY

Do you or any family member have/had any of the following? Please put an "X" for you, and "F" for family

☐ Depression	☐ Brain fog	☐ Headache
☐ Heart Attack	☐ Hypoglycemia	☐ Neuropathy/nerve problems
☐ Diabetes	☐ Anemia	☐ Poor Sleep
☐ Thyroid Disease	☐ Cancer	☐ Dizziness
☐ Gallbladder Disease	☐ High Blood Pressure	☐ Arthritis
☐ Kidney Disease	☐ Intestine Problems	☐ Weight gain
☐ Stroke	☐ Shortness of Breath	☐ Back Pain
☐ Fatigue	☐ High Cholesterol	☐ Carpal Tunnel

Is there a certain time of day any of these problems are better or worse? _____

_____

Are you taking any medications/supplements? _____ If Yes, please list _____

_____

Are you pregnant? _____ How many children? _____ How many pregnancies? _____

Are you breast feeding? _____

Any known allergies? _____ If Yes, please list _____

_____

Main Concerns:

1. _____ 2. _____

3. _____ 4. _____

How long have you had this/these concerns? _____

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What effect does this have on your body functions or quality of life? _____

_____

What would be different or better without this/these concerns?

☐ Diminished Stress ☐ More Energy ☐ Improved Self-Esteem ☐ Confidence ☐ Sleep

☐ Work ☐ Family ☐ Outlook

How have you addressed weight management in the past?

☐ Medications ☐ Vitamins ☐ Exercise ☐ Diet and Nutrition ☐ Other _____

How did the previous methods work for you? _____

What potential barriers do you foresee that would prevent the change you are looking for?

_____

_____

Do you feel it possible to eliminate or prevent these potential barriers? _____

What outcome would you like to see for this to be a success for you? _____

_____

_____

Please rate on a scale of 1-10 (1 being the lowest and 10 being the highest)

Energy Level	1	2	3	4	5	6	7	8	9	10
Quality of Sleep	1	2	3	4	5	6	7	8	9	10
How Important It Is For You To Resolve Your Health Concerns	1	2	3	4	5	6	7	8	9	10
What Is Your Level of Preparedness To Make Necessary Lifestyle Changes To Achieve Your Goals?	1	2	3	4	5	6	7	8	9	10

I am interested in:

Weight loss ☐ *Inch Loss* ☐ *Anti-Aging* ☐ *Metabolism Support* ☐

Long Term Results ☐

Instructions for the Day of Treatment

1. Do not eat 2 hours before or 2 hours after each treatment.

2. Drink plenty of water before your session.

3. Reduce or eliminate alcohol consumption while receiving these treatments (alcohol interferes with liver function, reducing its ability to process fatty acids).

4. No lotions or creams on the body parts you will be treating.

5. What to wear during treatment: bathing suit or under garments if you are comfortable wearing just that. Keep in mind where ever you want to lose inches the light has to be emitting on the skin.

Contraindications

Please be aware there are conditions were this therapy cannot be used.

Please let us know if you have any of the following:

1. Pregnancy or Breastfeeding
2. HIV/AIDS
3. Active Cancer
4. Serious Mental Disorders (claustrophobia, anorexia, bulimia, etc.)
5. Pacemaker
6. Any sort of liver disease (hepatitis, fatty liver disease, etc.)