activelife health and wellness

CONTOUR LIGHT

Patient Intake Form

Your success is our #1 priority.

Help us to help you achieve that success by filling out this questionnaire as completely as possible.

Name: _____ Date: _____

Address: _____

City, State, ZIP: _____

Cell #: _____ Home #: _____

Email: _____ Height: _____ Weight: _____

Date of Birth: _____ Age: _____ Sex: _____

Occupation: _____ Employer: _____

Are you currently under the care of a physician? _____

Do you exercise? _____ How often? _____ What type? _____

What do you expect from your Contour Light treatment? _____

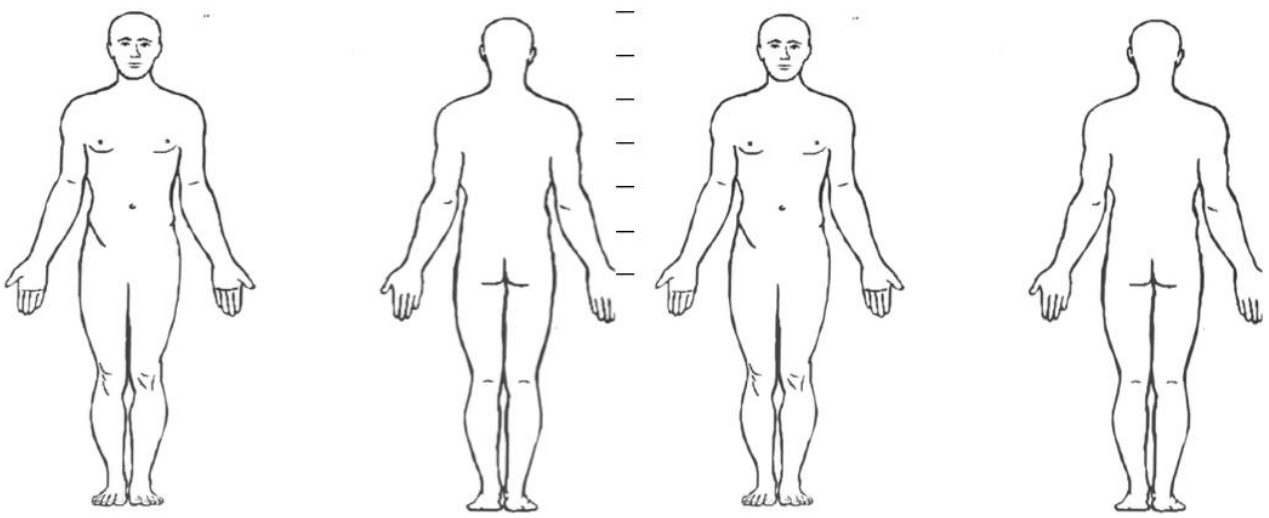
Why did you choose Contour Light? _____

How did you hear about us? _____

If you were referred by one of our clients, please tell us who we can send a Thank You note to:

_____

Areas of Your Body That You Want To Change



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Weight Loss Profile

Consultation Questions

What's your main goal: Weight Loss, Inch Loss or Overall Health?_____

What price range are you looking to stay in?_____

Have you been shopping around for any other weight loss programs?_____

On a scale of 1 to 10, what is your willingness to:

a. Learn?

b. Change?

What are you going to do when you reach your goal?_____

Do you feel your health and/or weight keeps you from doing anything?_____

What's the one thing you think is going to be hardest for you?_____

Are you someone who can be successful on your own or do you need accountability?_____

Who do you listen to when it comes to weight loss and overall health?_____

How long have you been on your weight loss journey?_____

What do you think was the cause of your weight gain?_____

What matters more, inches or weight? _____

How much weight have you decided to lose? _____

What methods failed to help you lose weight? _____

How many times a year do you diet? _____

Is successful weight loss a top priority (explain)? _____

How fast do you want to be thin, trim, and fit? _____

Do you feel tired, run down, and out of energy? _____

70% or above = GREEN
69% - 50% = YELLOW
49% or below = RED

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Weight Loss Profile

Dietary consultation involves a health profile whose purpose is not to establish a diagnosis, but rather to determine a client's health status in order to guide his or her weight loss plan. A client may be advised to seek medical advice based on his or her health profile.

Family Life

What is your marital status? ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Do you have any children? ☐Yes ☐ No Number of children: _____ Ages: _____

Eating Habits

Do you have breakfast every morning? ☐ Always ☐ Sometimes ☐ Never

Do you have a snack before lunch? ☐ Always ☐ Sometimes ☐ Never

Do you have lunch every day? ☐ Always ☐ Sometimes ☐ Never

Do you have a snack before dinner? ☐ Always ☐ Sometimes ☐ Never

Do you have dinner every day? ☐ Always ☐ Sometimes ☐ Never

Do you have a snack at night? ☐ Always ☐ Sometimes ☐ Never

Do you prefer: ☐ Sweet Foods ☐ Salty Foods ☐ Fatty Foods

☐Yes ☐ No Are you a vegetarian?

☐Yes ☐ No Are you currently on any special diets? If yes, please specify: _____

☐Yes ☐ No Do you smoke? If yes, how many packs per day? _____ For how many years? _____

☐Yes ☐ No Do you drink alcohol? If yes, what kind, how much, and how often? _____

How many glasses do you drink in a day? WATER _____ COFFEE _____

Medical Information

Please list any physicians you see and their specialty: _____

_____

_____

☐Yes ☐ No Are you taking any medication? If yes, please list: _____

_____

Please provide the following information if you had a history of or currently have:

☐Yes ☐ No Do you have stiffness, pain, or arthritic problems? If yes, where? _____

☐Yes ☐ No Do you have Diabetes. If yes, which type? _____

☐Yes ☐ No Do you tend to be hypoglycemic?

☐Yes ☐ No Have you had a cardiovascular event? If yes, please specify: _____

☐Yes ☐ No Do you have a history of arrhythmia?

☐Yes ☐ No Have you been diagnosed with Congestive Heart Failure (CHF)?

☐Yes ☐ No Do you have high blood pressure?

(Medical Information Continued…)

☐Yes ☐ No Have you been diagnosed with kidney disease?

☐Yes ☐ No Have you ever had kidney stones?

☐Yes ☐ No Have you ever had gout?

☐Yes ☐ No Irritable Bowel, Colitis, Diarrhea, Diverticulosis, Crohn's Disease, Constipation

☐Yes ☐ No Acid Reflux, Gastric Ulcer, Heartburn, Celiac Disease

☐Yes ☐ No Irregular Periods, Menopause, Fibrocystic Breasts, Painful Periods, Hysterectomy, Heavy Periods, Amenorrhea, Uterine Fibroma, Ovarian Cancer

☐Yes ☐ No Do you have a thyroid problem?

☐Yes ☐ No Depression, Anxiety, Anorexia, Bulimia, Panic Attacks

☐Yes ☐ No Rheumatoid Arthritis, Migraines, Psoriasis, Osteoarthritis, Fibromyalgia, Chronic Fatigue Syndrome, Lupus

☐Yes ☐ No Do you have Parkinson's disease?

☐Yes ☐ No Do you have cancer or in remission? If yes, for how long? _____

☐Yes ☐ No Are you generally fatigued or have low energy?

☐Yes ☐ No Are you pregnant or breastfeeding?

☐Yes ☐ No Do you get cold easily?

☐Yes ☐ No Do you have cold hands/feet?

☐Yes ☐ No Do you have other health problems? If yes, please specify: _____

_____

☐Yes ☐ No Do you have any FOOD allergies? If yes, please list: _____

_____

☐Yes ☐ No Are you currently taking vitamins, herbs, or supplements? If yes, please list and give the reason for taking it: _____

_____

Treatment Consent Form

Date: _____

I, _____ (name of patient), authorize Active Life Health & Wellness and staff to perform the Contour Light treatment and any other measures which in their opinion may be necessary.

This consent to treatment form explains the risks and benefits of the Contour Light treatments. Patient understands the following:

1. Results vary greatly from person to person. No result is guaranteed.
2. Contour Light is a treatment intended to be implemented in conjunction with a modification in diet and lifestyle as part of a complete protocol. The recommended diet and lifestyle is a critical part of the program and are essential in achieving the maximum results.
3. Temporary hyper pigmentation/hypo pigmentation (changes in skin color) on rare occasion may occur as a result of treatment.
4. Contour Light should not be used by patients with any of the conditions listed below.

Conditions that Prevent Treatment

Patient agrees (by initialing) that all of the following are true:

_____ I am over the age of 18

_____ I do not have and never had any of the following medical conditions:

- Cancer (active or within 1 Year of remission)
- HIV/AIDS
- Hepatitis C or D
- Uncontrolled High Blood Pressure

_____ I am not pregnant or breastfeeding

_____ I do not have a pacemaker

SIGNATURE

By signing below, patient agrees that provider may perform the Contour Light procedure for the purpose of body contouring. Patient understands and accepts the risks listed above and agrees that all information provided on this form is true and correct to the best of patient's knowledge.

Patient Signature _____ Date _____

DISCLOSURE TO THIRD PARTIES (OPTIONAL)

By signing below, patient agrees to permit provider and third parties authorized by provider to use patient's name, photos and/or videos in the marketing of the Contour Light system and procedure. Absent a signature, provider will not disclose patient's identity to any third party except as required by law.

Patient Signature _____ Date _____

CANCELLATION / MISSED APPOINTMENT POLICY

The technician has set aside your appointment time for you. Therefore, we require at least 24hrs advance notice if you need to cancel or reschedule your appointment. For all missed or cancelled appointments with less than 24 hours notice you will be charged a $25.00 cancellation fee.

If you are on a treatment plan and miss 2 consecutive appointments, your remaining appointments will be cancelled until you are able to resume a new regular treatment plan arranged with the technician.

Appointment reminder calls / text are a courtesy. Should you not receive a reminder call / text, it is still your responsibility to remember your appointment.

I have read and understand the cancellation / missed appointment policy

_____/_____
(Patients Signature) Date

If Patient is a minor, please provide parents or guardian's information.

_____ _____
(Name) (Relationship)

_____/_____
(Patients Signature) Date