Office use: Package\_\_\_ Visit 1: Visit 2: Visit 3: Visit 4: Visit 5: Visit 6:

|  |
| --- |
| Your Full Name: Referred by: Today’s Date:  |
| Address: City: State: Zip: |
| Home #: Work #: Cell #:  |
| Email Address:  |
| Height: Weight: Date of Birth: Age: Sex:  |
| Marital Status: For females: Are you pregnant? ❏ No ❏ Yes, how far along?  |
| How much water do you consume per day? |
| Occupation: How many hours per week do you work? |
| Are you currently under the care of a physician? ❏ No ❏ Yes, for what reason(s): |
|  |
| How stressed are you? (On a scale of 1 to 10, where 10 is the worst): |
| Have you ever had any health conditions that affected your liver? ❏ No ❏ Yes |
| Have you ever had any health conditions that affected your Stomach and digestive system? ❏ No ❏ Yes |
| Do you exercise? ❏ No ❏ Yes, how often? What type? |
| What area do you want us to focus on primarily? ❏ Abdomen ❏ Buttocks ❏ Thighs ❏ Chest ❏ Arms ❏ Neck ❏ Cellulite |

|  |
| --- |
| How long have you been overweight?  |
| What are your Weight Loss goals? 5-15lbs 15-25lbs 25+lbs |
| Are you embarrassed or physically hindered by your weight/appearance? ❏ No ❏ Yes, explain: |
| How important is weight or size reduction to you? (On a scale of 1 to 10, where 10 is the most important)  |
|  **Carbohydrate Sensitivity Check** (circle all that apply)**I am overweight \* I have a parent or sibling with Type 2 diabetes \* I often crave sweets or starches** **I tend to eat when I'm feeling stressed, anxious, or emotional \* I tend to gain weight in my belly****I often feel sleepy within an hour of eating \* I crave sweets in the morning \* I crave something sweet after a meal****I have trouble controlling how much I eat \* I often feel hungry within an hour of eating****I generally feel worse after I eat or drink \*** **I notice I have significant fluctuations in energy, mood, and attention after I eat or drink.** |
|  |

**Medical History** (circle all that apply)

High cholesterol Allergies Sinuses Surgeries Cancer Significant Trauma

High Blood Pressure TMJ Heart Disease Asthma Vertigo Liver Disease Diabetes Epilepsy Anxiety Ulcers Arthritis Sleep Problems

Thyroid Disease Hepatitis Kidney Disease Fatigue ADD Weight Problems Joint Pain Liver Disease Sleep Apnea Seizures Acid Reflux Infertility

List medications/prescriptions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This treatment may not be for individuals with any of the following conditions.

**I confirm the following (please check each line):**

\_\_I do not have a pacemaker. \_\_I do not have Herpes Simplex.

\_\_I do not have uncontrolled hypertension. \_\_I do not have a compromised immune system.

***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 this to be affordable.”

**Limitation to treatment (*please initial to acknowledge*):**

I understand there are no guarantees of this treatment as each individual's results may vary. No guarantee, warranty, or assurance has been made to me as to the results that may be obtained. It is important to know 100% certainty of success cannot be assured, as with any medical procedure. It is also important to note that in the vast majority of cases patients achieve satisfactory results (supported by numerous clinical studies), and in some cases results may vary and therefore not meet expectations of all patients completing a full series of treatments.

I understand that to achieve maximum results, I may require several treatments.

It has also been *recommended* that to achieve optimum results, an appropriate diet and regular exercise will assist to sustain and create a cumulative degree of overall spot fat reduction and body contouring.

Overall health, diet, and exercise need to be a part of any treatment program.

Red Light/LipoLaser technology is FDA cleared for reduction of pain, inflammation and fat reduction in adipose tissue.

I understand that if I have any health concerns, I am responsible to review this course of treatment with my personal physician prior to treatment.

Initial\_\_\_\_\_\_\_\_\_

**INFORMED CONSENT:**

I hereby authorize *Absolutely Beautiful, LLC* to perform the LIPOLASER, Contour Light, Whole Body Light Therapy Table, and/or other modalities for the purpose of aesthetic body sculpting and girth loss. I understand that this treatment involves the use of technology that penetrates through the skin. The nature and purpose of the treatment have been explained to my satisfaction. I understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I release Richsystems Inc., *Absolutely Beautiful, LLC*, the doctor, office staff, and technicians from liability associated with this procedure. I certify that I am a competent adult of at least 18 years of age. I understand all post treatment recommendations and agree to adhere to them; I freely assume any risks of complications or injury from known or unknown causes associated with, relating to, or otherwise arising out of this procedure. I have the right to consent to or refuse any proposed procedures at any time prior to or during its performance. I am aware that I must notify the clinician if my medical history changes prior to subsequent treatments. The consent form is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, and successors.

**Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_**