

# New Patient Intake Form

Congratulations on taking your first step towards reaching your weight loss and aesthetic goals. Today you will be qualified based on several factors including medical history and your level of commitment to achieving your desired results. During today's consultation we will evaluate your areas of concern and see if you qualify for one of our treatment programs. Your success relies on your dedication and compliance during your short time with us.

## Purpose for Baseline Test - Demo Session:

1. Perform baseline test to determine your body's response and absorption to laser light energy.
2. Demonstrate effectiveness of our technology. Treatment protocols are individualized and specific, your program will be determined after baseline test to assure maximum results.

## Demo Session Qualifications:

- Serious Candidates only.
- Must be at least 18 years of age or older.

## If selected: (check appropriate box)

<input type="checkbox"/>	I would like to start a program today.
<input type="checkbox"/>	After qualification, demonstration, and all my questions have been answered. I'm willing to move forward with treatment options that meet my needs and budget.
<input type="checkbox"/>	I am not interested in starting a program.

I consent to receiving a health screening. I realize that I am not receiving a diagnosis, treatment or prognosis for any medical or other condition that I may be experiencing. I acknowledge that I am receiving a demonstration only and agree to hold harmless the facility, owners, employees and any subsidiaries from any damage resulting from this demonstration. I understand and accept that visual documentation (photo and/or video) is necessary for evaluation, program monitoring and marketing. I hereby release and hold harmless this clinic and invisa-RED™ Technology from any reasonable expectation of privacy or confidentiality associated with the images and/or videos specified above. I further acknowledge that my participation is voluntary and that I will not receive financial compensation of any type.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date \_\_\_\_\_

<b>New Patient Interview</b>		<b>Date</b>
Print Name		
Address		
Phone		Email
Date of Birth		<input type="checkbox"/> Female <input type="checkbox"/> Male
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single		
Are you the primary decision maker / purchaser in your household? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Current Medical Conditions, Disorders and Diseases</b>		
<input type="checkbox"/> Cancer	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Vascular <input type="checkbox"/> Autoimmune
<input type="checkbox"/> Pregnant / Nursing	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Insulin Dependent <input type="checkbox"/> Skin
<input type="checkbox"/> Surgically Implanted Electro-stimulation devices		<input type="checkbox"/> Use of Medication that causes Photo-Sensitivity
<input type="checkbox"/> Endocrine System		<input type="checkbox"/> Tattoo with metallic ink
<b>Please check all symptoms that have applied to you in the last 60 days</b>		
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Back / Neck pain	<input type="checkbox"/> Inability to lose weight
<input type="checkbox"/> Sleeping difficulties	<input type="checkbox"/> Digestive problems	<input type="checkbox"/> Stress
<input type="checkbox"/> Restricted activities	<input type="checkbox"/> Irritable	<input type="checkbox"/> Depression / Anxiety
<input type="checkbox"/> Shoulder / arm pain	<input type="checkbox"/> Leg / Foot pain	<input type="checkbox"/> Headaches / Migraines
<input type="checkbox"/> Other		
<b>Personal Goals</b>		
<input type="checkbox"/> Change your Body		<input type="checkbox"/> Increase strength
<input type="checkbox"/> Lower Blood Pressure		<input type="checkbox"/> Reduce Stress
<input type="checkbox"/> More confidence		<input type="checkbox"/> More energy
<input type="checkbox"/> Sleep Better		<input type="checkbox"/> Other
<b>Select Program(s) of interest</b>		
<input type="checkbox"/> Weight Loss		How Much
<input type="checkbox"/> Body Contouring		Area of concern
<input type="checkbox"/> Cellulite		Area of concern
<input type="checkbox"/> Stretch marks		Area of concern
<input type="checkbox"/> Skin tightening		Area of concern

Please Answer the Following Questions	
Weight 1 year ago	Weight 5 years ago
How much did you weigh when you were most comfortable with yourself?	
What has had the biggest impact on your current weight condition?	

Over your lifetime how many diets / exercise programs have you tried?	
Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes how many packs per week
Drink Alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes how many drinks per week
How often do you eat out?	times per week
Please list potential obstacles: <input type="checkbox"/> None <input type="checkbox"/> Time <input type="checkbox"/> Budget <input type="checkbox"/> Commitment <input type="checkbox"/> Spouse / Partner <input type="checkbox"/> Other (please explain)	
How long have you been thinking about achieving your goals? <input type="checkbox"/> 1 mo. <input type="checkbox"/> 3 mo. <input type="checkbox"/> 6 mo. <input type="checkbox"/> 1 year or more	
On a scale from 1 to 10, how serious are you about accomplishing your goals? <b>Not Serious</b> <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <b>Most Serious</b>	
How will accomplishing these goals change your life?	

**FOR CLINIC USE ONLY**

Height _____	Age _____
Body Weight _____ lbs.	Body Fat _____ %
Body Weight x Body Fat % =	Pounds of Body Fat _____ lbs.
Body Weight - Pounds of Body Fat =	Pounds of Lean Weight _____ lbs.
Skin Tone: <input type="checkbox"/> Light <input type="checkbox"/> Medium <input type="checkbox"/> Dark	Eligible for Cellulite / Contouring <input type="checkbox"/> Yes <input type="checkbox"/> No

**BASELINE TEST - CONSULTATION SETTINGS**

Time Setting: 15 minutes	Pulse Setting: 3.5	Delay Setting: 0.2	
Energy Setting: <input type="checkbox"/> Light Skin Tone - 6 <input type="checkbox"/> Medium Skin Tone - 4 <input type="checkbox"/> Dark Skin Tone - 2			
Pre-treatment Measurements	Mid-waist	Upper-waist	Total inches
Post-treatment Measurements	Mid-waist	Upper-waist	Total inches
Baseline Results	Inches lost	Inches lost	Total inches lost

**\*Stretch-marks: Apply paddle to half of the stretch-mark only! Take a photo before and after**