DAMRON
CHIROPRACTIC & WELLNESS
Chiropractic | Rehab | Massage | Nutrition

New Patient Intake Form

Weight Loss & Body Contouring

Basic Patient Information

Name:	**Date:**
Street Address:	
City:	**State:** **Zip:**
Home Phone:	**Cell Phone:**
Email Address:	
Sex: M I F **Age:**	**Birth Date:** **Height:** **Weight:**
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced	
Occupation:	**Hobby:**
How did you hear about us?	

Health and Wellness History

Are you currently under the care of a physician? ☐ YES ☐ NO
Are you currently taking any medication? ☐ YES ☐ NO
Has your Doctor advised you to lose weight? ☐ YES ☐ NO
Do you have any dietary restrictions? ☐ YES ☐ NO **If so, please explain:**
How often do you exercise? ☐ YES ☐ NO **If so, what type?**
Do you feel stressed? ☐ YES ☐ NO

Check ALL that apply to you:

□ Heart Condition □ Epilepsy/Seizures
□ Pregnant □ Might be pregnant
□ Taking heart medication/blood thinners □ Undergoing chemotherapy
□ Breast feeding
□ Known adverse reactions to Niacin or B vitamins

PLEASE CONTINUE TO THE FOLLOWING PAGE

FOR THIS NEXT SECTION PLEASE ANSWER THE FOLLOWING QUESTIONS HONESTLY SO WE CAN DO OUR BEST TO HELP YOU REACH YOUR GOALS.

Check ALL areas of treatment that interest you:

□ **Weight Loss** □ **Cleansing and Detoxification** □ **General Wellness** □ **Body Wraps** □ **More Energy** □ **Stress Reduction** □ **Other**
Did you know that all treatments above are 100% safe? □ YES □ NO
Have you ever used any of the treatments above? □ YES □ NO
What do you consider to be your ideal weight?
How much weight do you want to lose?
How many times a year do you diet?
What is stopping you from losing weight on your own? **Please explain:**
What have you tried in the past that failed? **Please explain:**
Does your weight problem make you physically uncomfortable? □ YES □ NO **If yes, please explain:**
Does your weight problem cause physical pain? □ YES □ NO **If yes, please explain:**
Are you embarrassed by your excessive weight? □ YES □ NO **If yes, please explain:**
Does being overweight and unhealthy limit your activities? □ YES □ NO
Do you binge eat? □ YES □ NO
Do you suffer from uncontrollable cravings? □ YES □ NO
Do you feel that food controls you? □ YES □ NO
Do you eat because of your emotions? □ YES □ NO
Do you eat between meals? □ YES □ NO
What do you choose to eat between meals?

Briefly describe your daily eating behaviors:
Do you feel that your eating behaviors are normal? □ YES □ NO
Do you feel tired, run down, or out of energy? □ YES □ NO
Is successful weight loss a top priority? □ YES □ NO
How fast do you want to be slim, trim, and fit?
What's more important to you: fast or permanent?
Does your family support your weight loss efforts? □ YES □ NO
Is your family excited that you're working with us? □ YES □ NO
Can you remember being at your ideal weight? □ YES □ NO **Please describe what it was like being at your ideal weight:**

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Informed Consent and Release of Liability Form

Name: (First)_____ (Last)_____DOB_____

Program and Background

You have requested treatment utilizing LED light therapy. This treatment is the application of red and near infrared wavelengths, which causes fat within the fat cells to leak out and accumulate in the interstitial space. This excess fat is removed by the body's lymphatic system and excreted without negative side effects or downtime. Any medical or cosmetic procedure carries risks, complications and varied results. The purpose of this document is to inform of the nature of this product and its risk. LED therapies have been cleared by the FDA.

Procedure

Initially you will consult with a therapist to determine if you are a candidate for the LED therapy. You will have the opportunity to ask questions or voice concerns you may have regarding this treatment. If it is determined you are a candidate for this procedure, then paperwork, measurements, pre and post treatment photos (upon your approval) and suggested course of treatment will be given. This treatment should be used in conjunction with a healthy diet and exercise. You should consult a health care professional before beginning any new fitness program to determine if your body is physically able.

Risks/Discomfort

This treatment is non-invasive. During treatment there should be no discomfort. The client may feel the warmth of the light. This therapy is suitable for anyone over 18 who does not have any of the following issues:

Pregnancy, Breast Feeding, Recent Cancer, Heart Disease, Pacemaker or Metal Pins or Plates.

Benefits

LED light therapy has become more prominent and has been used in many studies for pain management and recently by cosmetic surgeons before liposuction with FDA clearance. The potential benefit of this treatment is body contouring without surgery. Problem areas or excess pockets of fat can be targeted, however the most commonly treated areas are the stomach, hips, flanks, and thighs. Results vary and no guarantee is implied or suggested that desired results will be achieved. Also, these results rely heavily on what each patient is doing outside of the office. If instructions and rules are not followed, the results will not be as optimal.

Voluntary Cosmetic Procedure

_____**(Initial)** I understand that this is a strictly voluntary cosmetic procedure. No treatment is necessary or required and this LED therapy has been chosen by myself (the client).

_____**(Initial)** I have been informed of the potential risks and side effects of this therapy including but not limited to redness, swelling, heat sensitivity, pain, increase bowel movements and increased urination. The risks, potential damages and adverse side effects have been explained to me and I fully understand them.

_____**(Initial)** I understand that each body is different and may require more or less treatments depending on the client's diet, exercise, metabolism and body type. I understand the treatment is most successful if I also maintain a healthy diet and commit to an exercise program.

_____**(Initial)** I know that if after the treatment program I over eat, the results of this treatment may be reversed.

_____**(Initial)** I understand that no guarantee has been given as to the results that may be obtained by this treatment. I have read this informed consent and certify that I understand its contents in full. I have had enough time to consider the information and feel I am sufficiently advised to consent to this procedure. I hereby give my consent to have this procedure. If at any time during the procedure I experience pain or discomfort of any kind, I agree to inform the staff immediately and/ or terminate the session at my discretion.

_____**(Initial)** I duly authorize the technicians to perform the procedure for the purpose of body contouring, lymphatic drainage, improvement of cellulite and skin tightening. I am aware that clinical results may vary depending on individual factors, medical history, patient compliance with pre/post treatment instructions, and individual response to treatment. If I do not make an effort to address my diet and exercise, the results achieved may not be retained.

_____**(Initial)** I have reviewed this consent form. My consent and authorization for this procedure are strictly voluntary. By signing the informed consent form I grant authority to perform the described treatment. The purpose of this procedure, risks, complications, alternative methods of treatment have been fully explained to my satisfaction. Cosmetic indications for these procedures include but are not limited to cellulite reduction, treatment of problem fat areas, skin tightening, and skin rejuvenation. Increased redness to the area for up to 12 hours may be experienced (although this is unlikely). Normal activities may be resumed following the treatment. Any photos taken will be used to show the clients progress and may be used in marketing ads.

Questions and Explanations

By signing below, you certify that this procedure has been explained to you and that you have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and understand that no guarantee can be given as to the final results obtained. You are fully aware that your condition is of a cosmetic concern and that the decision to proceed is solely based upon your expressed desire to do so. You are aware that this procedure may/can cause slight hypo/hyper–pigmentation of the skin and treatment is taken at your own risk (recent tattoo areas should be avoided). Any further questions can be directed to one of our specialists. Furthermore you are of lawful age and legally competent to sign this aforementioned release, and that you understand the terms herein is contractual and not a mere recital; You have signed this document of your own free will.

Whole Body Vibration Plate Exercise Risks

Whole Body Vibration Plate Machines are scientifically calibrated exercise machines designed to force your muscles to stretch and contract rapidly in small increments, replicating the same action which occurs during traditional exercising. Vibration exercises use your body weight and gravity to it's fullest potential. Please do not use a whole body vibration plate or any other exercise device without getting approval from your doctor.

Whole body vibrations is not recommended if you are: pregnant, diabetic with complications such as neuropathy or retinal damage, have a pacemaker, recently underwent surgery, suffer from Epilepsy or Migraines, have herniated disks, spondylolisthesis, spondylolysis, have cancer or tumors, have recent joint replacements, have metal pins or plates, or have any other concerns about your physical health. These contra-indications do not mean that you are not able to use a vibration or other exercise device, but it is recommended that you consult your physician first.

_____**(Initial)** I understand that using a whole body vibration machine workout is a strictly voluntary physical activity chosen by myself (the client). If at any time I experience pain or discomfort of any kind, I agree to inform the staff immediately and/or terminate the exercise.

OUR PRIVACY POLICY

We value your privacy, and are committed to maintaining your security and confidentiality in the use of any information you choose to share with us. We do not disclose identifiable information to any third party without your consent. Further, we do not sell, rent, or otherwise allow the unauthorized outside use of personal information such as names, addresses, phone numbers, or e-mail addresses in our database without your permission. Copies of this form and signature will be valid as if original if this document is digitally scanned. If any part of this Release is found to be invalid by the courts having jurisdiction, or becomes inoperative for any reason, such invalidity shall not affect the validity and enforceability of any other provision of this release.

Cancellation Policy

* We require a 24 hour cancellation notice.

* If I cancel within 24 hours of a reserved session, I might incur a $35 no-show fee

If I fail to show up or am more than 5 minutes late, I will lose or forfeit my session due to staff wages and fees paid for my session. Our cancellation policy has been created to ensure that our loyal clients are not disturbed by the tardiness of clients who do not show up on time, or who cancel within 24 hours of an appointment. When reserved sessions are unattended, this means that loyal clients missed the opportunity of having that particular time period.

Purchase and Reservation Policy

Sessions will only be confirmed and allowed up to the amount of pre-paid sessions. All sales are final and non-refundable. We reserve the right to terminate any client's session, package, or contract, without refunding any monies if the client has broken any terms or policies. All purchases are final, non-refundable and non-transferable.

* I understand if I have purchased and pre-paid for a first-time customer promotion, that I may not use or purchase another first-time promotion without consent. I further state that I am of lawful age and legally competent to sign this aforementioned release. The procedures, alternatives and risks have been explained to me and I have been given the opportunity to ask questions. I understand it is my responsibility to inform the staff is there are any changes to my medical history. I understand the terms herein is contractual and not a mere recital. I have signed this document of my own free act.

I HAVE CAREFULLY READ, UNDERSTOOD AND ACKNOWLEDGE ALL OF THE ABOVE STATEMENTS.

_____	_____
Client's Name	Client Signature Date
_____	_____
Staff Member's Name	Staff Member's Signature Date