ADVANCE LASER LIPO AND WEIGHT LOSS

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New Client Form

Patient Name: _____ Date: _____

Address: _____

City:_____ State: _____ Zip Code: _____

Email:_____

Phone:_____ Date of Birth: _____

How did you find out about our weight loss program? _____

Are you currently pregnant, breast feeding, have active cancer, pacemaker or cholecystitis? ❑ Yes ❑ No

(If yes, you are not eligible to participate in this program)

Do you experience any of the following conditions even if they are minor and go away on their own?

❑ High Blood Pressure	❑ Digestive Problems	❑ Chronic Inflammation
❑ Cancer	❑ Numbness	❑ Hypoglycemia
❑ Heart Disease	❑ Osteoporosis	❑ Thyroid Problems
❑ Fibromyalgia	❑ Headaches	❑ Chronic Fatigue
❑ Hip/Knee Pain	❑ Upper Back Pain	❑ Sinus/Allergy
❑ Diabetes	❑ Arthritis	❑ Other
❑ Neck Pain	❑ Stress/Irritability	

1. Are you currently on any medications and for what health condition?

_____

_____

2. Why do you currently want to lose weight?

_____

_____

3. How long have you struggled with your weight?

_____

4. Have you tried other weight loss plans and if so, what have you tried?

_____

_____

5. What were your results?

_____

_____

6. How long did you keep the weight off?

_____

7. Do you currently take nutritional supplementation? (if "yes" is the patient taking EFA's? They will need to discontinue EFA's while on this program)

_____

8. Do you have any other health challenges that you feel is important for us to know about?

_____

_____

9. What are your current weight loss goals?

_____

CHIROTHIN WEIGHT LOSS PROGRAM INFORMED CONSENT AND RELEASE OF LIABILITY

I understand that my use and consumption of any ChiroThin product or engaging in any weight loss program including the type that is to be used in conjunction with ChiroThin, have inherent risks to my health and well-being, including but not limited to headaches, nausea, dizziness, vomiting, fatigue, pain, loss of consciousness, shortness of breath and other ailments. I understand as well that rapid weight loss of over 1-2 lbs. per week is considered by most in the weight loss medical community to be excessive and may lead to ailments similar and in addition to those mentioned above. Therefore, I understand that my failure to follow the weight loss program exactly as described to me by my physician or chiropractor can result in severe temporary and/or permanent medical conditions in addition to those mentioned above. I understand that I am not use or consume any of the ChiroThin products if I am pregnant or think I might be pregnant. I understand that, as a dietary supplement, ChiroThin has not been approved by the FDA or any Federal or State authority. I additionally understand that The ChiroThin Weight Loss Program is not meant to diagnose, treat or cure any disease or medical condition and that I am to undergo participation in the ChiroThin Weight Loss Program only under doctor supervision. I also understand that I should consult with my doctor prior to starting ANY exercise or nutritional supplement program. I understand that, if I experience any ailment, including but not limited to headaches, nausea, dizziness, vomiting, fatigue, pain, loss of consciousness, shortness of breath and other ailments, I should immediately stop using or consuming the ChiroThin product and, if my symptoms do not resolve immediately, I should consult my physician or go to the hospital emergency room. I hereby consent to, and assume the risks associated with, the use and consumption of ChiroThin product and agree to follow the recommendations and instructions of my physician. I further agree not to use or consume any ChiroThin product without the advice, counsel, and recommendations of my physician. I hereby release, discharge and agree to indemnify my physician(s), ChiroNutraceutical, their agents, servants employees and affiliates from any and all liability, claims, causes of action and demands for personal or bodily injury or death that I or my personal representatives might have or might hereafter acquire through my use or consumption of ChiroThin products.

Printed Name: _____

Signature: _____ Date: _____

Advance Lipo Laser and Weight Loss

WELLNESS QUESTIONAIRE

MENTAL/EMOTIONAL STATE

Rate based on a frequency scale of 1-5. 1= Never 2= Rarely 3= Occasional 4= Regularly 5= Constantly

Presence of negative/ feelings or negative energy	1 2 3 4 5	Being overly worried about small things.	1 2 3 4 5
Moodiness, temper, or angry outbursts.	1 2 3 4 5	Difficulty thinking or concentrating.	1 2 3 4 5
Difficulty falling or staying asleep.	1 2 3 4 5	Feelings of depression or anxiety.	1 2 3 4 5

LIFE ENJOYMENT

Rate based on the level of enjoyment experienced. 1= Extensive 2= Considerable 3= Moderate 4= Slight 5= None

Experiences of relaxation, ease, or well-being.	1 2 3 4 5	Compassion and acceptance of others.	1 2 3 4 5
Interest in maintaining a healthy lifestyle, diet, etc.	1 2 3 4 5	The level of recreation in your life.	1 2 3 4 5
Confidence in your ability to deal with adversity.	1 2 3 4 5	Time devoted to things you enjoy.	1 2 3 4 5

OVERALL QUALITY OF LIFE

Rate based on the level of enjoyment experienced. 1= Delighted 2= Mostly Satisfied 3= Mixed 4= Dissatisfied 5= Unhappy

Your personal life.	1 2 3 4 5	The handling of the problems in your life.	1 2 3 4 5
Your spouse/significant other.	1 2 3 4 5	Your physical appearance.	1 2 3 4 5

YOUR CURRENT WELLNESS QUESTIONAIRE SCORE

Your Physical Health _____

Your Mental/Emotional Health _____

Your Stress Evaluation _____

Life Enjoyment _____

Overall Quality of Life _____

Total Score _____