IMPACT Wellness & Weight Loss

LIPOMELT
RED LIGHT THERAPY

First Name: _____ Last Name: _____ Sex: ☐M ☐F DOB: _____

Height: _____ Current Weight: _____ Goal weight: _____

Email Address: _____ Marital Status: _____ Occupation: _____

Address: _____

Cell Phone: _____ Are you pregnant? _____

What made you want to do something about your weight today? _____

_____

How much weight would you like to lose? _____

How long have you been overweight? _____

How important is weight or size reduction to you? (1-10) _____

How many pounds per week would you like to lose? _____

Are you embarrassed about your weight/ appearance? _____

Do you currently exercise? How often and when did you start? _____

How much water do you consume per day? _____

Which do you want to focus on? ☐ Abs ☐ Buttocks ☐ Thighs ☐ Chest ☐ Arms ☐ Neck

☐ Cellulite ☐ Other _____

What benefit would reaching your weight loss goal provide you in regards to your:

HEALTH? _____

WORK? _____

RELATIONSHIPS? _____

HOBBIES: _____

Do you eat breakfast regularly? _____ Do you crave sweets? _____

Do you experience pain? Where? _____

What is your current pain level? (1-10) _____

Are you currently under care of a physician? For what? _____

Have you ever had a health condition that affected your liver? _____

Ever had cancer? _____ How stressed are you? (1-10) _____

Do you feel tired, run down or lacking energy? _____

Do you have any medical conditions? (check all that apply)

- ☐ None
- ☐ Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Fatigue
- ☐ Hot Flashes
- ☐ Kidney/Liver Disease
- ☐ Metabolic Disease
- ☐ Osteoporosis
- ☐ Sleeping Disorders
- ☐ Ulcers
- ☐ Acid Reflux Disease
- ☐ BE-polar
- ☐ Chronic Back Pain
- ☐ Eating Disorder
- ☐ Gastrointestinal Disease
- ☐ Hypertension (high blood pressure)
- ☐ Lung/Pulmonary Disease
- ☐ Migraines
- ☐ Pancreatitis
- ☐ Stroke
- ☐ Other
- ☐ Allergies
- ☐ Bone/Joint Problems
- ☐ Depression
- ☐ Frequent Heartburn
- ☐ Heart Disease
- ☐ Immune System Disease
- ☐ Menopause
- ☐ Neuromuscular Disease
- ☐ Sensitive Skin Problems
- ☐ Thyroid

Check off any of the following symptoms you have experienced in the last 6 months:

- ☐ Tension Across Top of Shoulders
- ☐ Numbing/Tingling in Arms/Hands
- ☐ Numbing/Tingling in Legs/Feet
- ☐ Pain In the legs
- ☐ Pain in the feet
- ☐ Other (explain)_____
- ☐ Tired/Fatigued
- ☐ Difficulty Sleeping
- ☐ Allergies
- ☐ Digestive Problems
- ☐ Carpal Tunnel
- ☐ Low Back Pain
- ☐ Neck Pain
- ☐ Tension/Headaches
- ☐ Fibromyalgia
- ☐ Hormonal Problems

Which of the above bothers you the most? _____

How long have you had it? _____

How often does It occur? _____

What activities would you like to do if this was not a problem? _____

_____

In addition to losing weight, if there was a way to eliminate this other problem would you want to?

☐ Yes ☐ No

What have you tried to relieve/get rid of this problem?

- ☐ Medications
- ☐ Exercise
- ☐ Other
- ☐ Physical Therapy
- ☐ Nutrition
- ☐ Nothing
- ☐ Chiropractic Care
- ☐ Stretching

Support System:

After 18 months, people who reduced their calorie intake and had another person regularly check in with them about their progress lost almost twice as much weight as those who didn't have a support system. Social support adds accountability. A friend, family member or co-worker can be your weight-loss mentor, the important thing is to review your progress together at least weekly.

Tell us who will be in your support system from your:

Family: _____ Phone: _____

Friend: _____ Phone: _____

Co-Worker: _____ Phone: _____

Of these 3 people, who would be the most supportive? _____

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____