SUPERIOR HEALTHCARE LLC
LASER-LIPO

CLIENT APPLICATION

PLEASE PRINT. All requested information must be completed. If any question does not apply, please enter the term "N/A."

Last Name_____First Name_____M.I._____Date of Birth_____Age_____

Home Address_____
Street/City/State/Zip Code

Nickname : _____ Race / Ethnicity: _____ Gender: MALE / FEMALE _____

Social Security #_____Home Phone_(____)_____Cell Phone_(____)_____Work Phone_(____)_____

Employer_____Occupation_____May we contact you at work? Y/ N Home? Y/ N

Marital Status †S †M †D †W Spouse's Last Name_____First Name_____M.I._____

Responsible Party †Self †Spouse †Other If "Other," relationship to you?_____Responsible Party Phone_(____)_____

Responsible Party Information: If "Self," state "Same." Last Name_____First Name_____DOB._____

Do we have permission to discuss your condition with or provide information from your chart to your spouse or other named individual? Y / N
(If Yes, please list the person below)
Last Name_____First Name_____M.I._____Relationship to you_____

Primary Care
Physician_____Phone_(____)_____

Who may we thank for this referral?_____ Your email address:
_____

Emergency Contact: Phone Number:

*** We focus on your ability to be well. Our goals are to first address the issues that brought you to this office and second, to offer you the opportunity of improved health, wellness and quality of life. Answering the following questions will give us a profile of the specific stresses past and present that you face and allow us to better assess the challenges to your health potential.*

Which area(s) of your body are you interested in treating for fat loss reduction?
€ Chin € Arms € Abdomen € Love Handles € Back € Thighs € Hips € Buttocks

Which area(s) of your body are you interested in treating for the improvement of cellulite?
€ Chin € Arms € Abdomen € Love Handles € Back € Thighs € Hips € Buttocks

CURRENT WEIGHT: _____ GOAL WEIGHT: _____

CURRENT DRESS/PANT SIZE _____ GOAL DRESS/PANT SIZE _____

When was the last time you were at your ideal weight/dress size? _____

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Health History

Are you **Pregnant**? €Yes €No
Are you **Breastfeeding**? €Yes €No

Cancer:

Do you have Cancer? €Yes €No
Are you in Cancer remission? €Yes €No

Epilepsy:

Do you have Epilepsy? €Yes €No

Photosensitive:

Are you Photosensitive? €Yes €No

Liver Function:

Do you have liver problems? €Yes €No
If so, please specify _____
If so, are you under the care of a physician? €Yes €No
Are you taking medication? €Yes €No
If so, please list: _____

Diabetes:

Do you have diabetes? €Yes €No (skip this section)
If so are you under care of a physician? €Yes €No
If so, which type?
€ Type I € Type II € Insulin required (diabetes pills followed by insulin)
Is your blood sugar level monitored? €Yes €No
If so, by whom? €Myself €Physician €Other: specify _____
Are you taking any medication? €Yes €No
If so, please list: _____

Cardiovascular:

Do you have pacemaker? €Yes €No

Have you had a cardiovascular event? €Yes €No (skip this section)
If so, please specify: _____
How long ago? _____
If so, are you under the care of a physician? €Yes €No
Are you taking medication? €Yes €No
If so, please list: _____

Do you have hypertension (high blood pressure)? €Yes €No (skip this section)
If so, do you have your blood pressure checked? €Yes €No
If so are you under the care of a physician? €Yes €No
Are you taking medication? €Yes €No
If so, please list: _____

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Digestive Function:

Do you have: €Irritable colon €Colitis €Diarrhea
€Diverticulitis €Crohn's disease €Constipation

If so, are you under the care of a physician? €Yes €No
Are you taking medication? €Yes €No
If so, please list: _____

NAME: _____ **DATE:** _____

Stomach Function:

Do you have: €Acid reflux €Gastric ulcer €Heartburn

If so, are you under the care of a physician? €Yes €No
Are you taking medication? €Yes €No
If so, please list: _____

Thyroid Function:

Do you have thyroid problems? €Yes €No
If so, please specify _____
If so, are you under the care of a physician? €Yes €No
Are you taking medication? €Yes €No
If so, please list: _____

Musculoskeletal: **CERVICAL – THORACIC – LUMBAR SPINE**

Check symptoms that you are currently experiencing or have over the last 10 years.

o Neck Pain	o Numb/Tingling Arms/Hands	o Numbness/Tingling Legs/Feet
o Radiating Pain Shoulder	o Pain on Deep Breathing	o Coldness Legs/Feet
o Radiating Pain Arms/Hands	o Mid Back Pain	o Muscle Cramps Legs/Feet
o Weakness in Grip	o Pain into Ribs/Chest	o Lower Back Pain
o Coldness in Hands	o Pain into Hips/Legs/Feet	

Have any of the above symptoms affected your daily activities or ability to reach your weight lose goals?

- o Yes
- o No

If so, please explain: _____

LIST ANY OTHER MEDICATIONS YOU ARE CURRENTLY TAKING, ALLERGIES & HEALTH CONCERNS YOU MAY HAVE, OR ANYTHING ELSE YOU THINK SHOULD BE KNOWN:

AUTHORIZATION TO TREAT

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I, the undersigned client, hereby authorize Superior Healthcare/NC FAT LOSS appointed staff to administer such treatment as is necessary. I hereby certify that I understand the advantages and possible complications. I also certify that no guarantee or assurance has been made as to the results that may be obtained.

Client Signature _____ Date _____

Superior Healthcare/NC Fat Loss Technician
Signature_____Date_____

NAME: _____ **DATE:** _____

What, exactly, is your goal? _____

_____

Why is that your goal? (physical concern, depression, vanity?). Why is it an issue? _____

_____

What are you doing to get there? _____

_____

What are you willing to do to *(insert goal here)*? _____

_____

Identified Fat Storing Triggers _____

_____

Have you ever detoxed your body? _____ If so, what was used and result? _____

Do you currently exercise? _____ If so, how many times per week on average? _____

What types of exercise do you do? _____

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Patient Recommendations Made:

NAME: _____ **DATE:** _____

Please answer these questions very carefully.
Only answer to know what you will do for 3 or more weeks. Not what you want to do, or know you should do, what you will actually do, every day, for 3 weeks. Answer honestly, it is not about what you should or shouldn't do, but what you will do.

Answer A, B or C or D to these questions
All questions must be answered.

1. Are you willing to Drink half your weight in ounces of filtered water – Reverse Osmosis, Britta or Pure type Carbon Block Filter, Spring water – pretty much anything but tap water
    A. Every Day, and Only Water
    B. Every Day, mostly, with some other beverages
    C. I will drink more purified water, but not half my body weight in ounces
    D. Be Lucky if I get any water in most days

2. Are you willing to not eat 1 hour before or 2 hours after the treatments – this helps burn the fat being released from the fat cells as energy
    A. Will do this every session
    B. Will do this most sessions, but maybe not the full 3 hour window
    C. Will do some of this with some sessions, for some time
    D. Going to eat whenever I am hungry no matter what

3. How much activity are you willing to do? – to help burn some of the extra fat released as energy in the body.
    A. I will burn 500+ Calories with additional exercise 5 days a week – doing strength training exercise at least 2 of those 5 times - lifting weights, rowing, anything were you use the muscles against resistance, not just aerobics
    B. I will burn around 500 calories with additional exercise each day I do a lipolaser session – and do some strength training activities.
    C. I will do some form of mild exercise each day I do the lipolaser session
    D. Probably not going to do any exercise while I am doing the program

4. Are you willing to do a Detox program
    A. I will do it faithfully, every day, without ever missing a day
    B. I will remember most days to do it

C. I am probably not going to do the detox program, or miss a lot of days if I do

5. Are you willing to eat better?
   A. I will eat almost no refined carbohydrates – Refined carbs are stuff like white bread, pasta, sugar, anything ending with "ose" in the ingredients, sweets, candy, etc. – Only Fresh and pure Foods
   B. I will eat more fresh and pure foods like fruits, vegetables, fresh meat, seafood, whole grains, etc.
   C. I will try and eat better, when it is convenient for me, maybe a little less.
   D. I am going to eat the same things and the same amounts I always have.

NAME: _____ **DATE:** _____

6. Are you willing to change your way of eating, based on the metabolic typing guidelines
   A. I will only eat foods for the first 2 weeks that match my metabolic type – and slowly add back in other foods
   B. I will eat more foods in line with my metabolic type when I make food choices
   C. I will look at my metabolic type and maybe sometimes make food choices in accordance with it.
   D. Not interested in changing how I eat or knowing my metabolic type

7. Are you willing to do a Detox and Purification System to better help you reach your goals
   A. Yes, fully, for 3 weeks, which means almost completely raw food, lots of fruits and vegetables, with a lot of limitations
   B. Yes, willing to do the detox and supplements, and eat better
   C. No, don't want to do the program

8. Are you willing to do the nutritional consultation and symptoms survey checklist and take the recommended supplements –to help you reach your goals

   A. Yes, I will fill out the questionnaire, buy and take the supplements the symptoms survey recommends.
   B. Yes, I will fill out the questionnaire, and may buy and take some of the supplement recommendations.
   C. No, not willing to do this

9. Are you willing to have an in office evaluation of any symptomatic pain that is affecting you from reaching your healthcare goals.
   -**In most cases this is covered by your health insurance**.
   A. Yes
      -if yes a copy of your insurance care many be requested to verify your insurance coverage.
   B. No

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NAME : _____ DATE: _____

Determining your dominant Metabolic Type

These Questions are ranked in order of importance, with the most emphasis being put on how coffee, particularity caffeine, reacts with your system.

1. Coffee - caffeineated
    A. I do well on coffee (as long as I don't drink to much)
    B. I can take it or leave it.
    C. I don't do well with coffee. It makes me jittery, jumpy, nervous, hyper, nauseated, shaky, or hungry.
2. Appetite – My appetite is usually
    A. Low, weak, or lacking. I can go a long time with out eating and not even notice.
    B. Normal. Don't notice it being either strong or weak.
    C. Noticeably strong or above average.
3. Meal portions
    A. I don't eat that much. Definitely less than average. Doesn't take much to get me full.
    B. I don't seem to eat more or less than other people.
    C. I generally eat large portions of food, usually more than most people.
4. Weight Gain
    A. Meats and fatty foods cause me to gain weight.
    B. No particular foods seem to cause me to gain weight, but I'll gain weight if I eat too much and don't get enough exercise
    C. I tend to gain weight eating too many carbs.
5. Weather
    A. I do best in warm or hot weather, can't take the cold
    B. Temperature doesn't matter that much. I do pretty well whether it's hot or cold.
    C. I do best in cool or cold temperatures. Can' take the heat.

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