CONTOUR LIGHT

Client Intake Form

Your success is our #1 priority.

Help us to help you achieve that success by filling out this questionnaire as completely as possible.

Name: _____ Date: _____

Address: _____

Home #: _____ Work #: _____ Cell #: _____

Email: _____ Height: _____ Weight: _____

Age: _____ Sex: _____

Are you currently under the care of a physician? _____

Do you exercise? _____ How often? _____ What type? _____

What do you expect from your Contour Light treatment? _____

Why did you choose Contour Light? _____

If you were referred by one of our former clients, please tell us who we can send a Thank You note to:

_____

Weight Loss

How much weight have you decided to lose? _____

What methods failed to help you lose weight? _____

How many times a year do you diet? _____

Is successful weight loss a top priority (explain)? _____

What new activities will you become involved in after losing weight? _____

How fast do you want to be thin, trim, and fit? _____

Do you feel tired, run down, and out of energy? _____

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Areas Of Your Body That You Want To Change