Patient 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?____________________________

CONTOUR
LIGHT

Areas Of Your Body That You Want To Change