



Weight Management Intake Form

Today's Date: _____

Name: _____ (First) (Middle) (Last) Nickname: _____

Date of Birth: _____ Age: _____ Birth Sex: M F Occupation: _____

Address: _____ (Street) (City) (State) (Zip code)

Cell: _____ Home: _____

Work: _____ Email: _____

Emergency Contact: _____ Relationship: _____

Telephone Number: _____

How Did You Hear About Us?

Internet Friend Drive-by TV Newspaper Magazine Other: _____

If referred by a friend, please give us their name for referral credit: _____

How do you rate your overall health? GOOD FAIR POOR

Are you currently under the care of a physician, NP, PA, specialist, or chiropractor? Yes No

If yes, please list **name** and date of last visit. _____

Health and Wellness History

Has your doctor advised you to lose weight? Yes No

Do you have any dietary restrictions? Yes No

Please explain: _____

How often do you exercise? _____ What type of exercise? _____

Do you feel stressed? Yes No

Please explain: _____

Check ALL that apply to you:

Pregnant

Might Be Pregnant

Breast Feeding

Currently Undergoing Chemotherapy

Do you binge eat? YES NO

Do you suffer from uncontrollable cravings? YES NO

Do you feel that food controls you? YES NO

Do you eat because of your emotions? YES NO

Do you eat between meals? YES NO

What do you choose to eat between meals? _____

Do you feel that your eating behaviors are normal? YES NO

Briefly describe your daily eating behaviors: _____

Does your family support your weight loss efforts? YES NO

Can you remember being at your ideal weight? YES NO

What do you remember most about it? _____

Commitment to weight loss: (please rate): (low) 1 2 3 4 5 6 7 8 9 10 (high)

List ALL medications & supplements you take (prescription & over the counter)

Drug Name:	Dosage:	How long have you taken & for what conditions?

Please list all known DRUG and FOOD allergies:

Drug Name/Food Name:	Reaction:

- Check ALL medical conditions that you may have had or currently have now:
- | | | |
|--|--|--|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Epilepsy/seizures | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Low Blood Sugar |
| <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Raynaud's | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Celiac Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Irritable Bowel | <input type="checkbox"/> Lyme Disease |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Asthma | <input type="checkbox"/> Chronic Fatigue |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Gall Bladder | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Kidney Infection/stones | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Migraine |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Goiter | <input type="checkbox"/> Vertigo/Dizziness |
| <input type="checkbox"/> High Blood Sugar | <input type="checkbox"/> Low Blood Pressure | |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Sinus Infection | |
- Other: _____

Please list all previous surgeries & dates:

Alcohol use? Yes / No Amount _____ Daily / Weekly / Socially

Tobacco use? Yes / Never / Former Smoker PPD _____ How many years? _____

Recreational Drugs? Yes / No / Never If yes, type? _____ How often? _____

Patient Consent Agreement:

I affirm that I have stated all my known medical conditions and allergies and have answered all questions honestly. I agree to keep the provider updated as to any changes in my personal/medical profile and understand that there shall be no liability to Southern Cosmetic Laser should I fail to do so. Complications are rare, however, should any post complications arise necessitating care at a medical or emergency facility, clients are responsible for any and all charges incurred.

I understand all treatments at Southern Cosmetic Laser are considered cosmetic and are completely voluntary and not covered by insurance. Although positive results are expected, there is no guarantee or warranty, expressed or implied of outcome results or patient satisfaction that may be obtained for any service or treatment performed at Southern Cosmetic Laser. Although highly unlikely, it is possible that you may not experience any noticeable results from treatments. I understand there are no specific guarantees concerning expected treatment results. I understand that with any treatment certain risks, complications or side effects from known or unknown causes could occur. I freely assume these risks and acknowledge and agree to hold Southern Cosmetic Laser and its employees harmless against any and all expenses, liability and claims.

I understand that I am financially responsible for all charges in full at the time of treatment. Payments are due and payable on day of service. Any unused treatments, prepaid series or "banked" treatments must be used within one (1) year of purchase or be in process according to treatment plan within one (1) year of purchase. Unused treatments expire after one year. All sales are final, non-transferable. There are no refunds. Clients requesting credit for partially used prepaid package-price treatments, price defaults back to the individual regular service price. All prices reflect our cash discount. Cash discount works with cash or debit card using a pin number. Credit Card transactions incur a non-cash adjustment. Services may be denied if consents and policies are not signed.

_____ I give SCL permission to contact me through emails, text, and phone regarding my appointments.

_____ I have received and signed a copy of SCL Policies explaining cancellations, no shows, payments, etc.

Client Name (Please Print): _____

Signature: _____

Date: _____

Southern Cosmetic Laser Policies

Appointments: If this is your first appointment, please arrive 20 minutes before your appointment to fill out the paperwork. Or you may download New Patient Form on our website and bring it to your appointment. Please bring your list of medications and skincare products you are currently using. A before-photo will be taken at your first appointment as part of your client record. If you are unable to keep your appointment, a 24-hour notice is required. If you arrive late, your service may be shortened, or your appointment may have to be rescheduled. You can be charged up to the full price of your scheduled service.

_____ **(Initial) Booking Reservations, Cancellations, No-Shows & Rescheduled Appointments:** Consultations and appointments require a credit card on file. Cancellations or appointment rescheduling must be 24 hours prior to your appointment. In the event of a no show, failure to reschedule or failure to cancel an appointment without a 24-hour notice, a minimum of \$78 will be charged to your credit card on file plus any applicable fees. Treatments that require a longer booking time are subject to a higher no show/cancellation fee. Repetitive no shows or rescheduling accrue additional fees. By providing a credit card, you are consenting to your card being charged. No refund or credit will be issued. We reserve the right to charge up to the full-service price for no shows, cancellations or rescheduled appointments. Arriving late may result in a reduced appointment time, or your appointment may have to be rescheduled.

Complications and Results: Complications are rare. However, should post complications arise necessitating care at a medical or emergency facility, clients are responsible for any and all charges incurred. Although positive results are expected, there is no guarantee or warranty, expressed or implied, of the results that may be obtained for any service, treatment or procedure performed at Southern Cosmetic Laser.

Deposits, Services & Payments: SCL provides cosmetic services (fee for services); therefore, insurance is not accepted. All payments are due and payable on day of service. All deposits are non-refundable. All sales are final, non-transferable. There are no refunds. Some services require a deposit in advance. Therefore, before a service is performed, please consider all the required protocols and side effects. Cosmetic services are elective. There are no guarantees as to the outcome results or patient satisfaction. We are committed to client satisfaction and are available to answer any questions you may have before your purchase. All prices reflect our cash discount. Cash discount works with cash and debit card using a pin number. Credit Card transactions incur a non-cash adjustment.

Banked Prepaid Service Series: Most banked series expire one year from date of purchase. However, some exceptions may apply with shorter expiration dates such as VIP Facials, promotional series, etc. Clients requesting credit for partially used prepaid series package-price treatments, price defaults back to the individual regular service price.

Appointment for a Minor: Minors (under the age of 18) must be accompanied by a parent or legal guardian during their first appointment. A special minor clause can be indicated by a parent or legal guardian for the minor to be seen unattended for any additional appointments.

We are a medical practice using laser equipment. Unfortunately, we are unable to accommodate children. Therefore, to ensure the safety of our patients and to provide you an optimal consult and treatment, we request that you do not bring your children to your appointment. If you bring children, you may be asked to reschedule your appointment.

Southern Cosmetic Laser reserves the right to refuse treatment and/or dismiss a client from any service at any time. It is at the full discretion of Southern Cosmetic Laser to determine whether a client is a candidate for any service provided. Upon request, a copy of these policies can be provided for you.

I have read, understand and agree to Southern Cosmetic Laser Policies set forth.

Print Name

Client Signature

Date