Lipo-Light of Rock Hill

Lipo-Light 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:_____

Female date of last menstrual cycle**:** _____

Marital Status:_____Education:_____College Degree:_____

Major:_____Occupation:_____Favorite Hobbies:_____

Do you enjoy your work?_____

Do you feel stress (explain)?_____

Are you currently under the care of a physician?_____

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

Do you get angry often?_____Are you happy (if not, why)?_____

What worries you most?_____

What do you expect from your **Lipo-Light** treatment?_____

Why did you choose us for **Lipo-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 long have you been overweight?_____

How much weight have you decided to lose?_____

How many times have you failed at weight loss?_____

What methods failed to help you lose weight?_____

Does your weight problem make you physically uncomfortable (explain)?_____

Does your excessive weight limit you and your activities (explain)?_____

How many times a year do you diet?_____

Do you suffer from uncontrollable cravings (explain)?_____

Do you feel out of control?_____

Do you eat because of emotions (explain)?_____

Are you embarrassed about your weight?_____

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

Will you purchase a new wardrobe when you lose weight?_____

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

Are other members of your family overweight?_____

Briefly describe your eating behavior: _____

Do you believe weight loss has to be painful?_____

Do you believe weight loss can be enjoyable?_____

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

Do you feel your eating behavior is normal?_____

Does your family support your weight loss efforts?_____

Does being overweight limit your social life?_____

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

Can you remember being your ideal weight (explain)?_____

_____

Has being overweight caused you pain and suffering (describe physical and emotional pain)?_____

Circle the most important element in deciding to use our services (circle one):

Effectiveness (your results)

Time (how fast you get results)

Service (how we respond to your needs)

Affordable (what we charge)