Weight Loss

blueprint to Weight Loss

activelife health and wellness

PERSONAL INFORMATION

Name _____ ***Date*** _____

Address _____

City _____ ***State*** _____ ***Zip*** _____

Phone *(Mobile)* _____ *Home* _____

Email _____

Date of Birth _____ Age _____ Height _____ Weight _____

Occupation _____ ***Employer*** _____

Who may we thank for referring you to our office?

Friend or Family _____ ***Health Care Provider*** _____

Online Search _____ ***Wellness Class*** _____ ***Other*** _____

MEDICAL HISTORY

Your success is our #1 priority.

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

Do you or any family member have/had any of the following? Please put an "**X**" for you, and "**F**" for family

_____Depression	_____Brain Fog	_____Headache
_____Heart Attack	_____Hypoglycemia	_____Neuropathy/ Nerve Problems
_____Diabetes	_____Anemia	_____Poor Sleep
_____Thyroid Disease	_____Cancer	_____Dizziness
_____Gallbladder Disease	_____High Blood Pressure	_____Arthritis
_____Kidney Disease	_____Intestine Problems	_____Weight Gain
_____Stroke	_____Shortness of Breath	_____Back Pain
_____Fatigue	_____High Cholesterol	_____Carpal Tunnel

Is there a certain time of day any of these problems are better or worse? _____

_____

Are you taking any medications/supplements? _____ If yes, please list _____

_____

_____

Any known allergies? _____ If yes, please list _____

_____

What is your marital status? Single Married Divorced Widowed

Are you pregnant? _____ How many children? _____ How many pregnancies? _____

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Main Concerns:

1. _____ 2. _____

3. _____ 4. _____

How long have you had this/these concerns? _____

What effect does this have on your body functions or quality of life? _____

What would be different or better without this/these concerns?

☐ Diminished Stress ☐ More Energy ☐ Improved Self-Esteem ☐ Confidence ☐ Sleep

☐ Work ☐ Family ☐ Outlook

How have you addressed weight management in the past?

☐ Medications ☐ Vitamins ☐ Exercise ☐ Diet and Nutrition ☐ Other _____

How did the previous methods work for you? _____

What potential barriers do you foresee that would prevent the change you are looking looking for?

Do you feel it possible to eliminate or prevent these potential barriers? _____

What outcome would you like to see for this to be a success for you?

Please rate on a scale of 1-10 (1 being the lowest and 10 being the highest)

Energy Level	1	2	3	4	5	6	7	8	9	10
Quality of Sleep	1	2	3	4	5	6	7	8	9	10
How Important It Is For You To Resolve Your Health Concerns	1	2	3	4	5	6	7	8	9	10
What Is Your Level of Preparedness To Make Necessary Lifestyle Changes To Achieve Your Goals?	1	2	3	4	5	6	7	8	9	10

I am interested in:

☐ *Weight loss* ☐ *Inch Loss* ☐ *Anti-Aging* ☐ *Metabolism Support*

☐ *Long Term Results* ☐ *Overall Health*

Patient Quality Of Life Survey

blueprint to Gut Health

activelife health and wellness

Patient Quality Of Life Survey

Name: _____ ***Date:*** _____

Please take several minutes to answer these questions so we can help you get better. ***(Please circle all that apply)***

1. How have you taken care of your health in the past?
   - **a.** Medications
   - **b.** Emergency Room
   - **c.** Routine Medical
   - **d.** Exercise
   - **e.** Nutrition/Diet
   - **f.** Holistic Care
   - **g.** Vitamins
   - **h.** Chiropractic
   - **i.** Other (please specify): _____

2. How did the previous method(s) work out for you?
   - **a.** Bad results
   - **b.** Some results
   - **c.** Great results
   - **d.** Nothing changed
   - **e.** Did not get worse
   - **f.** Did not work very long
   - **g.** Still trying
   - **h.** Confused

3. How have others been affected by your health condition?
   - **a.** No one is affected
   - **b.** Haven't noticed any problem
   - **c.** They tell me to do something
   - **d.** People avoid me

4. What are you afraid this might be (or beginning) to affect (or will affect)?
   - **a.** Job
   - **b.** Kids
   - **c.** Future ability
   - **d.** Marriage
   - **e.** Self-esteem
   - **f.** Sleep
   - **g.** Time
   - **h.** Finances
   - **i.** Freedom

5. Are there health conditions you are afraid this might turn into?
   - **a.** Family health problems
   - **b.** Heart disease
   - **c.** Cancer
   - **d.** Diabetes
   - **e.** Arthritis
   - **f.** Fibromyalgia
   - **g.** Depression
   - **h.** Chronic Fatigue
   - **i.** Need surgery

Patient Quality Of Life Survey

How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:

What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.) Give 3examples:

What are you most concerned with regarding your problem?

Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific

What would be different/better without this problem? Please be specific

What do you desire most to get from working with us?

What would that mean to you?

Trust Your Gut Wellness Evaluation

In medicine today, leaky gut aka intestinal permeability, isn't typically diagnosed. However that doesn't mean it's not affecting your health. Many health issues related to LGS go undiagnosed, misdiagnosed, or are ignored by traditional medicine. Please take the quiz to help our doctors evaluate how we can help your condition and any underlying triggering limiting your health in process

Let's getstarted.

Please circle any that apply to you prior to taking the quiz below:

Sub-Clinical symptoms including:
Headaches and migraines

Hormone imbalance including:
PMS
Emotional imbalance

Gastrointestinal issues including:
Abdominal bloating and cramps or painful gas
Irritable Bowel Syndrome
Ulcerative Colitis
Crohn's Disease and other intestinal disorders

Respiratory Conditions including:
Chronic sinusitis
Asthma
Allergies

Autoimmune Conditions including:
Diabetes Mellitus
Lupus
Rheumatoid Arthritis
Fibromyalgia
Chronic Fatigue

Developmental & social concerns including:
Austism
ADD/ADHD

Skin Conditions: (urticaria)
Eczema
Skin rashes
Hives

Please complete our TYG wellness quiz. While there's more to it than a single quiz, the answers below can give you a good idea of how happy your gut really is. Circle the number that most closely fits, then add up your results.

TYG Wellness Questionnaire	None	Mild	Moderate	Severe
Constipation and/or diarrhea	0	1	2	3
Abdominal pain or bloating	0	1	2	3
Mucous or blood in stool	0	1	2	3
Joint pain or swelling, arthritis	0	1	2	3
Chronic or frequent fatigue or tiredness	0	1	2	3
Food allergies, sensitivities or intolerance	0	1	2	3
Sinus or nasal congestion	0	1	2	3
Chronic or frequent inflammations	0	1	2	3
Eczema, skin rashes or hives (urticaria)	0	1	2	3

	None	Mild	Moderate	Severe
Asthma, hayfever, or airborne allergies	0	1	2	3
Confusion, poor memory or mood swings	0	1	2	3
Use of NSAIDS (Aspirin, Tylenol, Motrin)	0	1	2	3
History of antibiotic use	0	1	2	3
Alcohol consumption makes you feel sick	0	1	2	3
Ulcerative colitis or celiac's disease	0	1	2	3
Nausea	0	1	2	3
Weight Trouble	0	1	2	3

YOUR TOTAL: _____

Treatment Consent Form

Date: _____

I, _____ (name of patient), authorize Active Life Health & Wellness and staff to perform the Contour Light treatment and any other measures which in their opinion may be necessary.

This consent to treatment form explains the risks and benefits of the Contour Light treatments.

Patient understands the following:

1. Results vary greatly from person to person. No result is guaranteed.
2. Contour Light is a treatment intended to be implemented in conjunction with a modification in diet and lifestyle as part of a complete protocol. The recommended diet and lifestyle is a critical part of the program and are essential in achieving the maximum results.
3. Temporary hyper-pigmentation/hypo-pigmentation (changes in skin color) on rare occasion may occur as a result of treatment.
4. Patients should not use Contour Light with any of the conditions listed below.

Conditions that Prevent Treatment

Patient agrees (by initialing) that all of the following are true:

_____ I am over the age of 18

_____ I do not have and never had any of the following medical conditions:

- Cancer (active or within 1 Year of remission)
- HIV/AIDS
- Hepatitis C or D
- Uncontrolled High Blood Pressure

_____ I am not pregnant or breastfeeding

_____ I do not have a pacemaker

SIGNATURE

By signing below, patient agrees that provider may perform the Contour Light procedure for the purpose of body contouring. Patient understands and accepts the risks listed above and agrees that all information provided on this form is true and correct to the best of patient's knowledge.

Patient Signature_____ Date _____

DISCLOSURE TO THIRD PARTIES (OPTIONAL)

By signing below, patient agrees to permit provider and third parties authorized by provider to use patient's name, photos and/or videos in the marketing of the Contour Light system and procedure. Absent a signature, provider will not disclose patient's identity to any third party except as required by law.

Patient Signature_____ Date _____

CANCELLATION / MISSED APPOINTMENT POLICY

The technician has set aside your appointment time for you. Therefore, we require at least 24hrs advance notice if you need to cancel or reschedule your appointment. For all missed or cancelled appointments with less than 24 hours notice you will be charged a $25.00 cancellation fee.

If you are on a treatment plan and miss 2 consecutive appointments, your remaining appointments will be cancelled until you are able to resume a new regular treatment plan arranged with the technician.

Appointment reminder calls / text are a courtesy. Should you not receive a reminder call / text, it is still your responsibility to remember your appointment.

I have read and understand the cancellation / missed appointment policy.

_____/_____
(Patient's Signature) Date

If Patient is a minor, please provide parents or guardian's information.

_____ _____
(Name) (Relationship)

_____/_____
(Signature) Date