

PERSONAL INFORMATION

Name _____ **Date** _____
Address _____
City _____ **State** _____ **Zip** _____
Phone (Home) _____ **Mobile** _____
Email _____ **Date of Birth** _____
Age _____ **Height** _____ **Occupation** _____
Who may we thank for referring you to our office?
Friend or Family _____ **Health Care Provider** _____
Online Search _____ **Wellness Class** _____ **Other** _____

MEDICAL HISTORY

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

- | | | |
|--|--|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Brain fog | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Neuropathy/nerve problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anemia | <input type="checkbox"/> Poor Sleep |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Intestine Problems | <input type="checkbox"/> Weight gain |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> 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 _____

➔ Are you pregnant? _____ How many children? _____ How many pregnancies? _____
 Are you breast feeding? _____

➔ Any known allergies? _____ If Yes, please list _____

➔ 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 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

➔ PIVOTAL HEALTH

Patient Quality Of Life Survey

Name: _____

Date: _____

*Please take several MINUTES to answer these QUESTions so we can help you get better.
(Please circle as many 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. Didnotgetworse
 - 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

→ 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 3 examples:

→ 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?

Contour Light® Consent Form

This consent to treatment form explains the risks and benefits of the Contour Light treatments. Client understands the following:

1. Results vary greatly from person to person. No result is guaranteed. HOWEVER, if you don't lose AT LEAST 1-4" INCHES (Cumulative Measurements) in your very first session, we will give you a full refund.
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 hyperpigmentation/hypopigmentation (changes in skin color) on rare occasions may occur as a result of treatment.
4. Contour Light should not be used by clients with any of the conditions listed below.

Conditions that Prevent Treatment

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

DISCLOSURE TO CONTOUR LIGHT®

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

CANCELLATION POLICY

Please Kindly note, if you fail to cancel your appointment by close of business the day prior to your scheduled time, you will forfeit your session, Contour Light is a timed service, therefore no shows and late appointments will not be rescheduled. Thank you for your cooperation and understanding.

Client Signature _____ Date _____

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 get started.

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 and 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		None	Mild	Moderate	Severe
Constipation and/or diarrhea	0	1	2	3	Asthma, hayfever, or airborne allergies	0	1	2	3
Abdominal pain or bloating	0	1	2	3	Confusion, poor memory or mood swings	0	1	2	3
Mucous or blood in stool	0	1	2	3	Use of NSAIDS (Aspirin, Tylenol, Motrin)	0	1	2	3
Joint pain or swelling, arthritis	0	1	2	3	History of antibiotic use	0	1	2	3
Chronic or frequent fatigue or tiredness	0	1	2	3	Alcohol consumption makes you feel sick	0	1	2	3
Food allergies, sensitivities or intolerance	0	1	2	3	Ulcerative colitis or celiac's disease	0	1	2	3
Sinus or nasal congestion	0	1	2	3	Nausea	0	1	2	3
Chronic or frequent inflammations	0	1	2	3	Weight Trouble	0	1	2	3
Eczema, skin rashes or hives (urticaria)	0	1	2	3					

YOUR TOTAL: _____