Contraindications to Laser Treatment

Please underline any and all statements that apply to you.

Are you pregnant, trying to get pregnant, nursing?
Do you have high blood pressure that is not controlled?
Do you have light sensitive epilepsy?
Do you have cancer?
Do you have an infectious skin disease?
Do you have severe varicose veins?
Are you sick or have an active disease?
Do you have fever?
Do you have blood disorder such as Hemorrhagic disease, vascular ruptures?
Do you have any skin disease?
Do you have an immune system condition or autoimmune disease?
Do you have Lupus, Scleroderma or Vitiligo?
Do you have leukemia, hemophilia?
Do you have any sensitivity to light?
Do you have a history of melanoma, raised moles, suspicious skin lesions?

Do you have Keloid scar formation or skin healing problems?
Do you have an active infection, open lesion or cut, hives, hepatic lesions or cold sores?
Do you have tattoos or permanent make-up in the areas you want to treat?

Do you take Isotretinion (Acutane), St. John's Wort, tetracycline or any drug that is sensitive to sunlight?
Have you taken any of these medications in the last 12 months?

Do you have a pacemaker, or other implanted electronic device?
Are you an insulin dependent diabetic? * Need doctors OK to have the treatment.
Are you **under** 18 years old?

If you underlined any of these questions, unfortunately you are not a candidate for the laser therapy.

But... We may be able to still help you!

MEYER CHIROPRACTIC CENTER

Name: _____

Date: _____

MEYER CHIROPRACTIC CENTER

LASER FAT LOSS QUESTIONNAIRE

Congratulations on taking your first step towards reaching your weight loss and aesthetic goals. Today you will be qualified based on several factors including medical history and your level of commitment to achieving your desired results. During today's consultation we will evaluate your areas of concern and see if you qualify for one of our treatment programs. Your success relies on your dedication and compliance during your short time with us.

Purpose for Baseline Test - Demo Session:

1. **Perform baseline test to determine your body's response and absorption to laser light energy.**
2. **Demonstrate the effectiveness of our technology. Treatment protocols are individualized and specific, your program will be determined after baseline test to assure maximum results.**

Intro-Session Qualifications:

- **Serious Candidates only.**
- **Must be at least 18 years of age or older.**

If selected: (check appropriate box)

_____ I would like to start the program today.

_____ After being qualified, had the intro session, and all my questions answered, I'm willing to move forward treatment options that meet my needs and my budget.

_____ I am not interested in this type of program.

I, _____ consent to receiving a health screening. I realize that I am not receiving a diagnosis, treatment or prognosis or any medical or other condition that I may be experiencing. I acknowledge that I am receiving a demonstration only and agree to hold harmless the facility, owners, employees and any subsidiaries from any damage resulting from this demonstration. I understand and accept that visual documentation (photo and/or video) is necessary for evaluation, program monitoring and marketing. I hereby release and hold harmless this clinic and Invisa-RED™ Technology from any reasonable expectation of privacy or confidentiality associated with the images and/or videos specified above. I further acknowledge that my participation is voluntary and that I will not receive financial compensation of any type.

Signature: _____ Date: _____

Name: _____ Date: _____

Address: _____

City: _____ State: ____ Zip Code: _____

Phone: _____ Email: _____

Date of Birth: _____ Age: _____ Height: _____

Occupation: _____

Who may we thank for referring you to our office?
Friend/Family: _____ Wellness Class: _____
Health Care Provider: _____Online Search: _____
Other: _____

METOBOLIC QUESTIONNAIRE

Please check conditions or symptoms you currently have ("√") or had previously ("P") or ("F") Family member.

☐ AIDS/HIV	☐ Gout	☐ Kidney Disease	☐ Parkinson's
☐ Carpal Tunnel	☐ Headaches	☐ Liver Disease	☐ Hand Weakness
☐ Arthritis	☐ Pinched Nerve	☐ Heart Attack	☐ Weight Gain
☐ Neuropathy/Nerve		☐ Psychiatric Problems	☐ Rheumatoid Arthritis
☐ Asthma	☐ Menstrual Problems		☐ Stroke
☐ Impaired Balance		☐ Decrease Concentration	☐ Hearing Problems
☐ Eye Disease	☐ Heart Disease	☐ Memory Loss	☐ Cancer
☐ Back Pain	☐ Hepatitis	☐ Tumors	☐ Neck Pain
☐ Depression	☐ Hernia	☐ Difficulty Sleeping	☐ Ulcers
☐ Diabetes	☐ Herniated Disc	☐ Multiple Sclerosis	☐ Hypoglycemia
☐ Knee Pain	☐ Shoulder Pain	☐ Fatigue	☐ High Cholesterol
☐ Dizziness	☐ High Blood Pressure		☐ Intestinal Problems
☐ Elbow Pain	☐ Nausea	☐ Other _____	
☐ Drug Use	☐ Osteoporosis	☐ Sciatica	☐ Jaw Pain / TMJ
☐ Epilepsy	☐ Difficulty Breathing	☐ Brain Fog	☐ Thyroid Disease
☐ Pacemaker	☐ Gall Bladder Disease	☐ Anemia	☐ Shortness of Breath

☐ Check here if you are interested in the doctor presenting a solution for any conditions you are now experiencing.

EXERCISE ☐ None ☐ Light ☐ Moderate ☐ Heavy ☐ Daily ☐ Weekly

WORK ☐ Sitting ☐ Standing ☐ Office ☐ Light Labor ☐ Heavy Labor

LIFESTYLE ☐ Smoker ___ Packs Per Day. ☐ Alcohol ___ Drinks Per Day
☐ Coffee ___ Cups Per Day
☐ High Stress Reason: _____

From the METABOLIC QUESTIONNAIRE ABOVE

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

_____

_____

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

_____

_____

04 Are you pregnant? _____ How many children? _____ How many Pregnancies? _____
Are you breast feeding? _____

05 Any known allergies? If yes, please list.

06 _____

Main Concerns:

1. _____ 3. _____
2. _____ 4. _____

07 How long have you had this/these concerns?

_____

_____

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

_____

09 _____

_____

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

- ☐ Diminished Stress
- ☐ Family
- ☐ Confidence
- ☐ Work
- ☐ Improved Self-Esteem
- ☐ Sleep
- ☐ More Energy
- ☐ Outlook

10 **How have you addressed weight management in the past?**

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

11 **How did the previous methods work for you?**

_____

_____

12 **What potential barriers do you foresee that would prevent the change you are looking fo**

_____

_____

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

_____

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

_____

_____

15 **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 ☐ Anti-Aging ☐ Long-Term Results

☐ Inch Loss ☐ Metabolism Support

Name:	Date:

Please Answer the Following Questions:

How much did you weigh when you were most comfortable with yourself?

What has had the biggest impact on your current weight condition?

Over your lifetime how many diets / exercise programs have you tried?

How often do you eat out? times per week

Please list potential obstacles: □ None □ Time □ Budget □ Commitment □ Spouse / Partner □ Other (please explain)

How long have you been thinking about achieving your goals? □ 1 mo. □ 3 mo. □ 6 mo. □ 1 year or more

How will accomplishing these goals change your life? _____

_____

On a scale from 1 – 10, how serious are you about accomplishing your goals?

Not Serious 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. **Most Serious**

FOR CLINIC USE ONLY

Height _____ Age _____ BMI _____	Body Weight _____ lbs. Body Fat % _____%
Body Weight x Body Fat % =	Pounds of Body Fat _____ lbs.
Body Weight – Pounds of Body Fat =	Pounds of Muscle Weight _____
Skin Tone: □ Light □ Medium □ Dark	Body Age: _____

BASELINE TEST - CONSULTATION SETTINGS

Time Setting: 15 minutes	Pulse Setting: 3.5	Delay Setting: 0.2

Energy Setting: Light Skin Tone - 6 Medium Skin Tone - 4 Dark Skin Tone - 2

Pre-treatment Measurements	Mid-waist	Upper-waist	Total inches
Post-treatment Measurements	Mid-waist	Upper-waist	Total inches
Baseline Results	Inches lost	Inches lost	Total inches lost

***Stretch-marks: Apply paddle to half of the stretch-mark only! Take a photo before and after**

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 gut health go undiagnosed, misdiagnosed, or are ignored by traditional medicine. Please complete this evaluation to help our doctors determine how we can help your condition.

Let's get started

Please check any that apply to you:

Sub-Clinical Symptoms Including:

- ☐ Headaches
- ☐ Migraines

Hormone Imbalance Including:

- ☐ PMS
- ☐ Emotional imbalance

Gastrointestinal Issues Including:

- ☐ Abdominal bloating, cramps or painful gas
- ☐ Irritable Bowel Syndrome
- ☐ Ulcerative Colitis
- ☐ Crohn's Disease and other intestinal disorders

Respiratory Conditions Including:

- ☐ Chronic sinusitis
- ☐ Asthma
- ☐ Allergies

Joint Conditions Including:

- ☐ Knee, Shoulder, or Spine

Autoimmune Conditions Including:

- ☐ Diabetes Mellitus
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Fibromyalgia
- ☐ Chronic Fatigue

Thyroid Conditions Including:

- ☐ Hashimotos
- ☐ Hypothyroidism
- ☐ Hyperthyroidism

Developmental and Social Concerns Including:

- ☐ Autism
- ☐ ADD/ADHD

Skin Conditions Including:

- ☐ Eczema
- ☐ Skin rashes
- ☐ Hives

Circle the number that most closely fits, then add up your results.

	None	Mild	Mod	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	Mod	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
Gluten sensitivity or Celiac's disease	0	1	2	3
Nausea	0	1	2	3
Weight issues	0	1	2	3

YOUR TOTAL _____