invisa-RED® INTAKE FORM

PERSONAL INFORMATION

Full Name :

Date Of Birth : ____/____/____ **Gender** : ☐ Male ☐ Female

Address : ____

Phone Number : ____ **E-Mail** : ____

Status : ☐ Single ☐ Married ☐ Divorce ☐ Others

Are you the primary decision maker/ purchaser in your household?

☐ YES ☐ NO

TELL US ABOUT YOURSELF

Please Answer the Following Questions

Weight 1 year ago ____ Weight 5 years ago ____

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? ____

Do you smoke? ☐ Yes ☐ No If yes how many packs per week ____

Drink Alcohol? ☐ Yes ☐ No If yes how many drinks per week ____

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

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

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

How will accomplishing these goals change your life?

MEDICAL HISTORY

☐ YES ☐ NO Have you ever been diagnosed with cancer?

☐ YES ☐ NO Have you or do you currently have any heart conditions?

☐ YES ☐ NO Do you have medically implanted electrostimulation devices such as a pacemaker?

☐ YES ☐ NO Are you currently pregnant or nursing?

☐ YES ☐ NO Do you have any photosensitive skin conditions?

☐ YES ☐ NO Are you insulin dependant (diabetes)?

List of Medications Currently on.

_____.

PRECAUTIONS

- Adequate hydration should be maintained during treatment program. Drink 8-10 glasses of water per day in order to flush impurities from your body. Drink enough water to keep your urine clear.
- Do not apply any gels, lotions or essential oil on body areas that will be treated.
- Minor burns or blisters may result from light energy applied to the skin
- Light laser therapy may result in sluggish or flu like symptoms due to release of stored toxins by the body.

I consent to receiving a health screening. I realize that I am not receiving a diagnosis, treatment or prognosis for 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 _____

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