Shelton Medical Center
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Laser Lipo New Client History

Please answer all the questions below in full. As you answer, please be as specific and as detailed as possible.

Today's Date _____

Name _____ Age _____ Birthdate _____ Sex M F

Address _____ City_____ State ____ Zip _____

SS# _____ Marital Status S M W D Spouse Name _____

Home Phone _____ Work Phone _____ Cell Phone _____

Best Place To Reach You (circle one) Home / Work / Cell May we leave a voice mail message for you? Yes No

Employer _____ Occupation_____ Length of Employ_____

Email Address _____

How Did You Hear About Connecticut Disc & Laser Therapy Centers?

_____

1. In order of importance, what are your "problem areas"?

1. _____
2. _____

2. What have you tried up until now to get results?

_____

_____

3. What do you notice has worked?

_____

_____

4. What have you noticed has NOT worked?

_____

_____

Tobacco use: Yes / No How many packs per day? _____ How many years? _____

Alcohol use: Yes / No How many drinks per week? _____

Caffeine use: Yes / No Coffee / Tea / Soda How many cups per day? _____

Water: How many ounces per day? _____ Increase to: _____

How many meals per day? _____

Typical breakfast_____

Typical lunch? _____

Typical dinner? _____

Typical snacks? _____

Salt intake? Low / Medium / High

Sugar intake? Low / Medium / High

Do you use artificial sweeteners? _____ If so, what brand? _____

Do you exercise regularly? Yes / No What intensity? Low / Medium / High

What type of exercises? _____

How many hours of sleep per night? _____

List In Order Of Importance all OTHER Health Problems/Concerns.

1._____ How Long?_____

2._____ How Long?_____

3._____ How Long?_____

Women Only: Is there a chance that you could be pregnant? Yes / No

I consent to allow Dr. Dalfino to speak with me and perform an evaluation (if necessary) in order to determine if I am a good candidate for the non-surgical Laser Assisted Weight Loss / Fat Loss. It is also my understanding that the consultation is at no charge. The questions on this form have been answered completely and truthfully to the best of my knowledge.

_____

Patient / Client Signature Date

Have you had ANY of the following?

(Fill in the bubble to the left.)

GENERAL

O Chills
O Convulsions
O Dizziness
O Fainting
O Fatigue
O Fever
O Headaches
O Loss of Sleep
O Loss of Weight
O Nervousness
O Wheezing
O Bronchitis

CARDIOVASCULAR

O High Blood Pressure
O Low Blood Pressure
O Pain over Heart
O Poor Circulation
O Rapid Heart Beat
O Previous Heart Problem
O Slow Heart Beat
O Stroke
O TIA
O Swollen Ankles
O Varicose Veins
O Aortic Aneurysm
O Bruise Easily

DISEASES/CONDITIONS

O Appendicitis
O Anemia
O Arthritis
O Alcoholism
O Abdominal Surgery
O Bleeding Disorder
O Blood Clots
O Breathing Difficulty
O Cancer
O High Cholesterol
O Colon Problems
O Diabetes
O Depression
O Epilepsy
O Eczema
O Eating Disorder
O Glaucoma
O HIV+
O Heart Disease
O Hernia
O Headaches
O Influenza
O Kidney Disease
O Liver Disease
O Low Back Pain
O Mental Illness
O Measles
O Mumps
O Pleurisy
O Pneumonia
O Polio
O Prostate Problems
O Hyperthyroid
O Hypothyroid
O Rectal Surgery

EARS/EYES/NOSE/THROAT

O Asthma
O Bad Breath
O Colds
O Dental Difficulties
O Difficulty Swallowing
O Double Vision
O Ear Pain
O Gingival Bleeding
O Hearing Loss
O Hoarse Voice
O Mouth Sores
O Neck Mass
O Neck Tenderness
O Neck Stiffness
O Nasal Congestion
O Nasal Discharge
O Nose Bleeding
O Sinus Problems
O Sore Throats
O Thyroid Problem

GASTRO-INTESTINAL

O Gas
O Colon Trouble
O Constipation
O Diarrhea
O Gallbladder Trouble
O Hemorrhoids
O Liver Trouble
O Nausea
O Stomach Ache
O Poor Appetite
O Poor Digestion
O Vomiting
O Vomiting Blood
O Rectal Bleeding
O Bloating

GENITO-URINARY

O Blood in Urine
O Frequent Urination
O Inability to Control Urine
O Kidney Infection
O Painful Urination

FOR MEN ONLY

O Prostate Trouble
O Lump in Testicles
O Penis Discharge

FOR WOMEN ONLY

O Menstrual Cramps
O Excessive Menstrual Flow
O Hot Flashes
O Irregular Cycle
O Painful Periods
O Birth Control Pills
O Abnormal Pap Smear

MUSCLE/JOINT/BONE

O Pain
O Stiffness / Swelling
O Limited Range of Motion
O Joint Pain
O Weakness
O Muscle Atrophy
O Night Cramps
O Back Pain
O Muscle Pain or Cramps
O Cold Extremities
O Difficulty Walking

NEUROLOGIC

O Seizures
O Dizziness
O Hand Trembling
O Weakness
O Difficulty with Speech
O Loss of Memory
O Loss of Coordination

RESPIRATORY

O Chest Pain
O Chronic Cough
O Difficulty Breathing
O Coughing / Spitting Blood