AcuLaser
TREATMENT CENTRE

The following information is required prior to beginning your therapy. All information is confidential. E-mail is used solely for follow-up support and will not be sold to third parties.

Date:	**First Name:**	**Last Name:**
Address:		**City:**
State	**Zip Code:**	**Telephone:**
E-mail:		

How did you hear about AcuLaser? ☐TV ☐ Radio ☐Newspaper ☐Magazine ☐Internet ☐ Doctor ☐ Friend

Name of Doctor, Friend or Publication:

Do you consider yourself to be in good health? ☐ Yes ☐ No ☐ Somewhat

Which treatment are you interested in? ☐ Tobacco Cessation ONLY ☐ Tobacco Cessation/Weight Enhancement

Do you have or ever had any of the following?

☐ Stents ☐Allergies ☐ Nausea ☐COPD ☐Insulin ☐ Epilepsy ☐ Light sensitivity
☐ Insulin intake ☐ Metal implants ☐ Electrical implants ☐ Circulatory problems ☐Cancer _____
☐ Heart condition ☐ Chemotherapy ☐Kidney disease ☐ Other:_____ ☐ Pacemaker
☐ Skin sensitivity

Are you pregnant or trying become pregnant? ☐ Yes ☐ No

What medications do you take on a regular basis?

Drug:	Reason:
Drug:	Reason:
Drug:	Reason:
Drug:	Reason:

I, the undersigned, certify that all of the above information is true, and I have not omitted any pertinent information. I am in good physical condition. I am not/nor may be pregnant. I have been informed and understand the nature of the therapy and agree to receive the procedure by a certified laser technician. I agree to hold AcuLaser Treatment Centre harmless of any and all liability arising from or related to acts of omissions of this procedure. I understand that the information is confidential and proprietary to AcuLaser Treatment Centre. I further understand that no guarantee can or is made or implied as the success of the procedure. I understand that the procedure is non-medical and is not covered by any medical insurance plan. I understand that the procedure is complementary therapy and is not meant to replace medical care, and agree to consult my doctor prior to beginning any diet or exercise program. AcuLaser Treatment Centre does not diagnose or treat disease. I certify that I am over 18 years of age and do not have any medical conditions which make low level laser treatment inadvisable. I agree to follow the post-treatment instructions to the best of my ability.

Signature:	**Date:**

Are you a relaxed person? ☐ Yes ☐ No **Are you tense or nervous?** ☐ Yes ☐ No

How many cigarettes do you smoke per day? _____

Do you use any other nicotine products? ☐Yes ☐ No **If so, which ones?** _____

At what age did you begin using tobacco? _____

Have you tried quitting and failed? _____

Have you ever quit using tobacco for an extended period of time? _____

Where do you typically use tobacco? ☐ Home ☐ Work ☐ Car ☐ Outside ☐In hiding

Circle in which of these situations you have the strongest urge to use tobacco:

In bed	When you wake	With coffee	While driving	After meals
Watching TV	During Meals	On the phone	In the bathroom	Reading
Socially	At the computer	Doing yard work	Doing homework	Other: _____

Please indicate True or False:

I enjoy smoking/using tobacco.	☐ True	☐False
I like the taste.	☐ True	☐False
I like the smell.	☐ True	☐False
I'm quitting to please someone else.	☐ True	☐False

Check only one of the following:

☐ I have to quit, but I don't want to. I am being forced to quit due to work or health reasons.

☐ I have to quit, but I'm not sure I am ready.

☐ I want to quit to save my health or job.

☐ I AM QUITTING. I AM DETERMINED. I don't have to, I don't need to, **I WANT TO!!**

What do you imagine will be the benefits of no longer using tobacco?

_____

_____

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