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

Do you have or ever had any of the following?

☐ Stents ☐ Allergies ☐ Nausea ☐ Insulin ☐ Epilepsy ☐ Diabetes ☐ Kidney disease

☐ Gallbladder ☐ Metal implants ☐ Electrical implants ☐ Circulatory problems ☐ Cancer ______________

☐ Heart condition ☐ Chemotherapy ☐ Other:__________________ ☐ Pacemaker ☐ Skin sensitivity

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

List any medication you are currently taking:

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, treat, prevent or cure 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. AcuLaser Treatment Center is not affiliated with LiveWave, LLC.

Signature:	**Date:**

Most of the time I am (check one)

☐ Very relaxed ☐ Moderately relaxed ☐ Slightly tense ☐ Moderately tense ☐ Very tense ☐ A worrywart

How well do you sleep? ☐ Normal ☐ Restless sleeper ☐ Trouble falling asleep ☐ Trouble staying asleep

Were your parents overweight? ☐ Yes ☐ No **If yes, who?** ______________________________

Have you always been overweight? ☐ Yes ☐ No

Did the weight gain coincide with a traumatic event? ______________________________

Do you eat when you are hungry or do you eat out of compulsion? ☐ Hunger ☐ Compulsion

Do you eat past the point of feeling full? ☐ Yes ☐ No **Do you stress eat?** ☐ Yes ☐ No

Do you have trouble drinking enough water throughout the day? ☐ Yes ☐ No

What is your activity/exercise level? ☐ Sedentary ☐ Moderately active ☐ Very active

When do you overeat the most? ______________________________

What are your weight goals? ☐ Reduce cravings ☐ Eat cleaner ☐ Increase metabolism ☐ Improve health

☐ Self-confidence ☐ More energy ☐ Pleasing spouse/friend ☐ Buy new clothes Other: ______________

Check YES or NO for the following to determine your body's toxicity load

Item	Yes	No	Item	Yes	No
Processed food	☐ Yes	☐No	Fast food	☐ Yes	☐No
Organic fruits and vegetables	☐ Yes	☐No	More than 3 cups of coffee daily	☐ Yes	☐No
Red meats	☐ Yes	☐No	Non-filtered water	☐ Yes	☐No
Poultry	☐ Yes	☐No	Junk food	☐ Yes	☐No
Pork	☐ Yes	☐No	Use a microwave	☐ Yes	☐No
GMO foods	☐ Yes	☐No	Canned goods	☐ Yes	☐No
Artificial sweeteners	☐ Yes	☐No	Soda	☐ Yes	☐No
Preservatives and additives	☐ Yes	☐No	Eat out regularly	☐ Yes	☐No
Pre-packaged or pre-made foods	☐ Yes	☐No	Drink alcohol more than once a week	☐ Yes	☐No