In-Line Chiropractic Care New Client Red Light

1. Please enter your information.

First Name: _____ Middle Initials: _____ Last Name: _____ Date of Birth: _____

Gender:
○ Female ○ Male

Occupation
_____

Marital Status:
○ Single ○ Married ○ Separated ○ Divorced ○ Widowed

Street Address:
_____

Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Email: _____

2. How did you hear about us?

○ Facebook ○ Instagram ○ Google
○ Friend Other ○

3. Are you currently following any specific diet or exercise regimen to support your weight loss goals?

_____

4. What expectations do you have regarding the results you would like to achieve through our treatments?

_____

5. What methods have failed to help you achieve your goals?

_____

6. How important is it for you to achieve long-term, sustainable results in your body contouring journey?

_____

7. What factors are most important to you when deciding to commit to ongoing treatments? Is it the convenience, cost-effectiveness, or the desire to achieve optimal results?

_____

8. How much weight are you committed to losing?

_____

9. How often do you feel tired, run down, or out of energy?
10. Which of the following benefits of red light therapy are you most interested in achieving?

_____

- ☐ Improved Energy
- ☐ Better Quality Sleep
- Less ☐ Anxiety
- ☐ Tighten & Tone
- ☐ Smooth Wrinkles
- Muscle ☐ Recovery
- ☐ Joint Pain Relief
- Burning Fat / ☐ Losing Weight
- Reduce Cellulite ☐

11. Do you have any upcoming trips?

_____

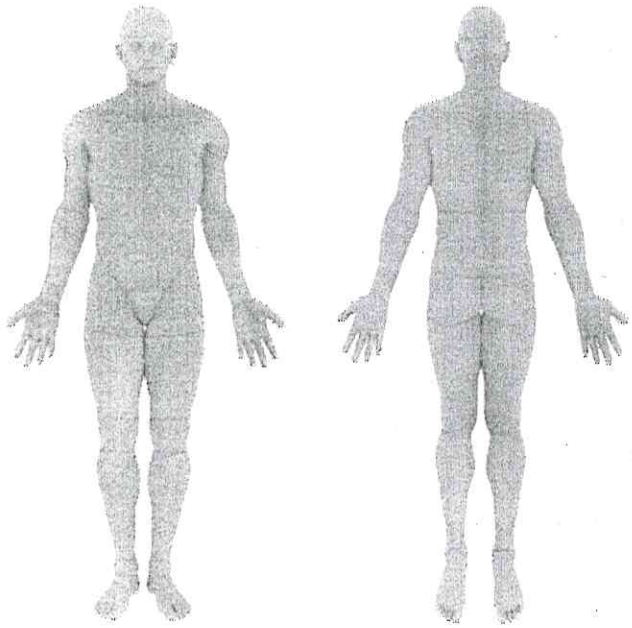
12. Which of our programs would you like to learn more about?

☐ Fat Loss Kit ☐ Cryo Slim ☐ Cryo Facial

13. Are you taking any medications? if yes, what are they?

_____

14. Which areas would you like to lose fat / shape and tone?



15. Please answer the questions below

	Anxiety & Constant Stress	Difficulty Sleeping	Leg Weakness & Cramps	Restless Leg	Poor Metabolism & Weight Control	Low Back pain	Neck Pain	Knee Pain
Past	Past	Past	Past	Past	Past	Past	Past	Past
Present	Present	Present	Present	Present	Present	Present	Present	Present

16. Please check all that apply

- ☐ Headaches and/or Migraines
- ☐ ADD/ADHD
- Diabetes ☐
- ☐ Emotional Imbalance
- ☐ Eczema
- Irritable Bowel Syndrome ☐
- ☐ Arthritis
- Abdominal Pain and/or Bloating
- Joint Pain ☐
- ☐ Constipation and/or Diarrhea
- ☐ Shoulder Pain
- Sciatica ☐
- ☐ Digestive Pain/Discomfort
- ☐ Asthma/Allergies
- Thyroid Issues ☐