

Date: \_\_\_/\_\_\_/\_\_\_

**COMPLIMENTARY CONSULTATION**

**SHORT FORM**

**Please answer the following questions completely, Thank You!**

Name: \_\_\_\_\_ Address: \_\_\_\_\_ Apt # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Work Number: \_\_\_\_\_ Cell Number: \_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ E-Mail: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

Sex: M F Marital Status: S M Spouse's Name: \_\_\_\_\_

How did you hear about our clinic and/or the Zerona Laser: \_\_\_\_\_

**PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY**

- \_\_\_ Diabetes
- \_\_\_ Cardiovascular disease
- \_\_\_ Hypothyroidism
- \_\_\_ Alcohol consumption; If so, how much? \_\_\_\_\_
- \_\_\_ Surgical intervention for weight loss
- \_\_\_ Taking medications; If so, please list: \_\_\_\_\_
- \_\_\_ Medical condition that causes bloating
- \_\_\_ Infection or wound to area to laser
- \_\_\_ Pregnant or nursing
- \_\_\_ Participation in clinical study or research in the last 90 days
- \_\_\_ Receiving disability benefits due to weight-related issues
- \_\_\_ Lymphatic or circulatory problems
- \_\_\_ Constipation
- \_\_\_ Frequent caffeine consumption (soda, coffee, tea, etc.); If so, how much? \_\_\_\_\_

**What are you hoping the Zerona Lipolaser will do for you?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_