"*STRAWBERRY LIPO LASER NJ*"
Inch Loss Intake Form

Name: Date:
_____

Date of Birth:_____ Cell Phone:_____

Address:_____

City: _____State:_____ Zip code:_____

Email:_____

How did you hear about us?_____

Medications:_____
_____

Allergies or Sensitivities:_____

Do you smoke? If so, how much?_____

Do you drink? If so, how frequent?_____

How much water do you drink daily?_____

Name: Date:

List any surgeries you have had (Include cosmetic)

Are you currently exercising? If so, how frequently?

Any physical restrictions?

Have you been pregnant? If so how many times?

Was it a C-section? How long ago?

Last menstrual cycle:

What diets, if any, have you tried?

What is your weight/inch loss goal?

Any health concerns I should know about?

Who do you know that would like great results from The Strawberry Lipo Laser NJ?

Name: _____
Telephone:_____