



## INFRARED BODY WRAP INTAKE FORM

This form is completely confidential. Please submit by email, fax, mail, or in-person before your appointment.  
To enter information, click on the gray box. Press "tab" or "click" to move to the next gray box. Save answers.

### PROFILE:

Name: \_\_\_\_\_ Gender:  M  F Age: \_\_\_\_\_  
Today's Date:     /     /     (dd/mm/yyyy)     Date of Birth:     /     /     (dd/mm/yyyy)

Address: \_\_\_\_\_

Telephone:     (Home)     -     -     (Cell)     -     -     (Work)     -     -

Email: \_\_\_\_\_

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

How did you hear about us?

Have you ever had an infrared body wrap session?      Y  N     When?

Why have you chosen to have an infrared body wrap session?

May we give you appointment reminder calls?      Y  N (phone)     -     -

May we leave you phone messages?      Y  N (phone)     -     -      same as above

Name of Medical Doctor / Family Physician: \_\_\_\_\_ Telephone:     -     -

### EMERGENCY CONTACT:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone:     (home)     -     -     (cell)     -     -     (work)     -     -



Please record your diet for the last 3 days:

	Day 1	Day 2	Day 3
Breakfast			
Lunch			
Dinner			

How often do you have a bowel movement?

Do you use laxatives?  Y  N

Do you tend towards?  constipation  diarrhea  both  other:

What is the color of your stool?

Any undigested food in stool?  Y  N

What is the shape of your stool?  Well-formed  Ribbon-like  Pellets  Other:

How many times have you been treated with antibiotics? For what condition(s)?

Have you ever used probiotics or yogurt after antibiotic use?  Y  N

What is your greatest health concern?

How does it limit you the most?

How committed are you towards making valuable changes?  Little  Moderate  Very

Would you be interested visiting with Dr. Cutler in regards to your health concern(s)?  Y  N  Maybe in the future

Is there any other information that you feel is important that has not been covered?