LIPOMELT

What You Need To Know For Best Results

1. Typically it will take **10-12 sessions** for significant and long-lasting results.

2. Please **keep your appointments** and make up any that you miss. This type of therapy is cumulative and consistency is important.

3. We recommend that you come **every other day** to allow your body time to process the extra fat.

4. Remember to take your **liver support** as directed.

5. **Drink water** before each treatment and continue throughout the day, as directed. This helps flush the fat and toxins from your system.

6. **Don't eat** 1 hour before and one hour after each treatment.

7. Some form of **exercise** for at least 10-20 minutes must follow each treatment to stimulate lymphatic and blood circulation and help process the fat that has been released.

8. **Reduce your overall caloric intake** while limiting starchy carbohydrates and simple sugars.

9. Please lessen or eliminate **alcohol** during the treatment process. Alcohol negatively affects the liver, which will work against this treatment, lessening the results.

10. Once you've achieved your goal, it is important that you stay on a regular monthly **maintenance program**.

Melt That Fat Away

(Please Print Clearly)

Your Name:	Referred by:	Today's Date:
Address:	City: State:	Zip:
Home #:	Work #:	Cell #:
Email Address:		
Height: Weight:	Date of Birth: Age:	Sex:
Marital Status:	Are you pregnant? ❑ No ❑ Yes, how far along?	
How much water do you consume per day?		
Occupation:	How many hours per week do you work?	
Are you currently under the care of a physician? ❑ No ❑ Yes, for what reason(s):		
How stressed are you? (On a scale of 1 to 10, where 10 is the worst):		
Have you ever had any health conditions that affected your liver? ❑ No ❑ Yes, explain:		
Have you ever had cancer? ❑ No ❑ Yes, explain:		
Do you exercise? ❑ No ❑ Yes, how often?	What type?	
Which do you want us to focus on? ❑ Abdomen ❑ Buttocks ❑ Thighs ❑ Chest ❑ Arms ❑ Neck ❑ Cellulite		

How long have you been overweight?
How much weight do you want to lose?
Are you embarrassed about your weight/appearance? ❑ No ❑ Yes, explain:
How important is weight or size reduction to you? (On a scale of 1 to 10, where 10 is the most important)
Are other members of your family overweight? ❑ No ❑ Yes
Do you feel tired, run down, or out of energy? ❑ No ❑ Yes, explain:

I clearly understand and agree that all services rendered are charged directly to me, and that I am personally responsible for payment.

Your Name (print): _____

Signature: _____ Date: _____

---------- DO NOT WRITE BELOW THIS POINT ----------

Provider's Notes: