



Real people. Real results. Guaranteed.

1-800-345-4381
Info@MyUltraSlim.com

Admission Form

First Name: _____ Last Name: _____ M.I. _____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ E-mail: _____

Location Where Service Is Provided: _____

Services To Be Provided: _____

What are your treatment goals?

How did you learn about these services?

How did you learn that these services are offered at this location?

Do you have any questions?

Signature

Date



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HEALTH HISTORY QUESTIONNAIRE

Name <i>(Last, First, M.I.):</i>	<input type="checkbox"/> M	<input type="checkbox"/> F	DOB:
Home Address :	Phone:		
Email:			
Location of Services:			

CHECK ANY CONDITION YOU CURRENTLY HAVE

Pregnant Now, or Trying	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Active Cancer Within A Year	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Kidney Problems	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Liver Problems	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Doctor said you should avoid light?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Autoimmune disease	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Lupus Erythematosus	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Albinism	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

CHECK ANY PHOTO-SENSITIVE MEDICATIONS THAT YOU TAKE

Gold or Gold 50	<input type="checkbox"/>	Hostacycline	<input type="checkbox"/>	Chlorpromazine	<input type="checkbox"/>
Fulvicin P/G or Fulvicin U/F	<input type="checkbox"/>	Lymericycline	<input type="checkbox"/>	Grifulvin V or Griseofulvin	<input type="checkbox"/>
Gris-Peg	<input type="checkbox"/>	Sumycin	<input type="checkbox"/>	Grisovin	<input type="checkbox"/>
Demecocycline	<input type="checkbox"/>	Folex	<input type="checkbox"/>	Ledermycin	<input type="checkbox"/>
Doxycycline	<input type="checkbox"/>	Ledertrexate	<input type="checkbox"/>	Cyclidox	<input type="checkbox"/>
Doryx	<input type="checkbox"/>	Methotrexate Sodium	<input type="checkbox"/>	Doxycyl or Doxytab	<input type="checkbox"/>
Dumoxin	<input type="checkbox"/>	PF	<input type="checkbox"/>	Noritet	<input type="checkbox"/>
Viacin	<input type="checkbox"/>	Aratac	<input type="checkbox"/>	Vibramycin	<input type="checkbox"/>
Lymecycline	<input type="checkbox"/>	Pacerone	<input type="checkbox"/>	Minocycline	<input type="checkbox"/>
Tetrasal	<input type="checkbox"/>	Amioderone	<input type="checkbox"/>	Minomycin or Minotabs	<input type="checkbox"/>
Cyclimycin	<input type="checkbox"/>	Codarone X	<input type="checkbox"/>	Terramycin	<input type="checkbox"/>
Oxytetracycline Be-oxytet	<input type="checkbox"/>	Terra-Cortril	<input type="checkbox"/>	Cotet	<input type="checkbox"/>
Oxypan	<input type="checkbox"/>	Trexall	<input type="checkbox"/>	Quinolone Derivatives	<input type="checkbox"/>
Ciprofloxacin	<input type="checkbox"/>	Methotrexate	<input type="checkbox"/>	Nalidixic Acid	<input type="checkbox"/>
Norfloxacin	<input type="checkbox"/>	LPF	<input type="checkbox"/>	Oflaxacin	<input type="checkbox"/>
Tetracycline Group	<input type="checkbox"/>	Mexate AQ	<input type="checkbox"/>	Achromycin or Acromysin V	<input type="checkbox"/>
Actisite	<input type="checkbox"/>	Thorazine	<input type="checkbox"/>	Bristacycline	<input type="checkbox"/>
Largactil	<input type="checkbox"/>	Tetrex	<input type="checkbox"/>	Helidac	<input type="checkbox"/>
Auranofin	<input type="checkbox"/>	Azathioprine	<input type="checkbox"/>	Chlorpromazine HC	<input type="checkbox"/>
Ridaura	<input type="checkbox"/>	Roaccutane	<input type="checkbox"/>		<input type="checkbox"/>
Sonazine	<input type="checkbox"/>	Isotretinoin Accutane	<input type="checkbox"/>		<input type="checkbox"/>

Client Signature

Date



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847-857-8011
chicagoultraslim.com

Model Release

For legality purposes, Barrington Back and Body must make digital records (photographs) of client treatments. Hence, I, the undersigned, hereby consent to allow Barrington Back & Body (which does business in its name and with registered business UltraSlim, LLC) to make digital recordings of me (photographs), and grant rights to Barrington Back & Body of said digital recordings for the purpose of before/after photos for use within the office, UltraSlim, LLC will not have rights to my photos.

Your identity will NEVER be revealed or compromised.

Your photos will NOT be used for marketing purposes without additional consent.

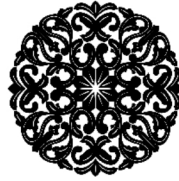
I understand that there will be no additional compensation or consideration for recording me or for any subsequent use. I represent that I am at least 18 years of age, have read and understand the foregoing, and am competent to execute this agreement.

Name: _____ Date: _____

Address: _____

Phone: _____ Email: _____

Signature: _____



Barrington Back & Body
CHIROPRACTIC & AESTHETIC REJUVENATION

455 W NW Hwy, Barrington IL 60010
847.857.8011

Cancellation Policy

In consideration of Barrington Back and Body, we ask that you give us 24-hour notice of any cancellation or appointment rescheduling needs.

We do understand that life happens, and not always 24 hours in advance. Because of this, we offer one [1] complimentary last-minute cancellation “pass” without incident. Any subsequent cancellations or reschedules, within the 24-hour time period before a scheduled appointment, will be subject to a \$30 cancellation fee, collected at the next appointment before treatment begins.

We thank you for your understanding in that this policy allows us to serve all clients fairly and permits us to offer openings to waitlist clients.

I hereby consent to the \$30 cancellation fee; in the event I need to cancel or reschedule within 24 hours of my scheduled appointment. This fee only applies after I have used my complimentary 1st time “pass”.

Name: _____ Date: _____

Signature: _____