Name _____

Phone (_____)_____

DOB(mm/dd/yy) _____/_____/_____

Emergency Contact _____ Phone # (_____)_____

Please note the following listed conditions are considered contraindications for the use of Far Infrared Saunas. Please indicate if any of the following apply to you:

1. Do you have uncontrolled high blood pressure? Yes No
2. Do you suffer from Congestive Heart Failure? Yes No
3. Are you presently intoxicated with increased consumption of alcohol? Yes No
4. Do you suffer from Parkinson's, Multiple Sclerosis? Yes No
5. Do you suffer from a Central Nervous System Tumor or Diabetic Neuropathy? Yes No
6. Are you pregnant? Yes No
7. Do you have a fever? Yes No
8. Have you had a recent joint injury (past 48 hours) that is still hot and swollen? Yes No
9. Do you have recent wounds from an operation or surgery? Yes No
10. Do you have a Pacemaker or defibrillator? Yes No

IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, YOU MUST GET A RELEASE FROM YOUR PHYSICIAN BEFORE USING INFRARED SAUNA.

Please indicate if any of the following apply to you:

1. Are you currently taking diuretics, barbiturates, beta-blockers or anti-histamines? Yes No

2. Are you under the age of 16 or over the age of 65? Yes No

3. Are you currently having a heavy menstrual period? Yes No

4. Do you have a metal pin, rod, artificial joint or any other surgical implants? Yes No

5. Do you have a hard time breaking a sweat? Yes No

IF YOU ANSWERED YES TO ANY OF THE ABOVE, YOU NEED TO BE CAUTIOUS. PLEASE SLIGHTLY OPEN THE DOOR OF THE SAUNA TO ALLOW COOL AIR TO COME IN IF YOU ARE TOO HOT. WE WILL SET YOUR FIRST SESSION AT A LOWER TEMPERATURE.

DISCLAIMER / WAIVER

I, the undersigned, consent to the Infrared Sauna Treatment. I understand that these procedures are for the purpose of detoxification and are not intended to take place of medical care or medications. I clearly confirm that I do not have any contraindications to the Infrared Sauna Treatments. I understand that I can discontinue my treatments anytime. I understand that I take full responsibility for my own health and well-being. I agree to pay my account in full for every treatment. I agree to disclose to The Elaine Sterling Institute, if my medical health history should happen to change during the time period of receiving Far-Infrared Sauna Treatments.

I have read the above disclaimer (including cautions and contraindications for the use of Far-Infrared Sauna) and I agree that I am not currently suffering with any of the above mentioned contraindications. I have read the recommendation sheet, I have been informed about the fees, I have had the opportunity to ask any questions about its content, and by signing below I agree to release Elaine Sterling Institute and its members from any liability in connection with the use of the sauna. We do not release your name to any third party. Step out of the infrared sauna immediately if you experience dizziness or are sleepy. In the rare event, you experience pain and / or discomfort, immediately discontinue sauna use.

Client Name _____ (please print)

Signature _____ Date _____