wave
WELLNESS

COLD PLUNGE INTAKE FORM

Name | Date of Birth

Address

City | State | Zip Code

Phone # | Email

Occupation

Emergency Contact Name | Phone #

How did you hear about us?

Medical History

Please check all that apply:

- ☐ ALS
- ☐ Bacterial Infection
- ☐ Circulatory Disorder
- ☐ Dermatitis
- ☐ Eczema
- ☐ Metal implants
- ☐ MS
- ☐ Neuropathy
- ☐ Parkinson's
- ☐ Rashes
- ☐ Severe Allergy to Cold
- ☐ Severe Raynaud's
- ☐ Viral Infection
- ☐ Wound Healing Disorder
- ☐ Other: _____

Are you currently taking any medications? Yes ☐ No ☐

If yes, please list:

Have you had any facial or other cryotherapy services in the past 90 days? Yes ☐ No ☐

If yes, please explain:

Do you have any allergies? Yes ☐ No ☐

If yes, please explain:

Have you had any surgeries in the past year? Yes ☐ No ☐

If yes, please explain:

Have you had aesthetic fillers, injectables or laser treatments in the last 6 months? Yes ☐ No ☐

Do you have any irremovable body piercings in the desired treatment area? Yes ☐ No ☐

Do you have any implants in the desired treatment area? Yes ☐ No ☐

BY SIGNING BELOW, I AGREE TO THE FOLLOWING:

I have completed this form to the best of my ability and knowledge. I agree to inform the technician of any changes in the above information. I agree that I do not have any condition(s) that would make the requested treatment unsuitable. I agree to waive all liability toward my technician and the spa for any injury or damages incurred due to any misrepresentation of my health.

Client Signature _____ Date _____

wavewellnessohio@gmail.com | 330-407-3124
255 2nd Street NE, Suite B – New Philadelphia, OH 44663

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COLD PLUNGE TREATMENT RELEASE FORM

_____ If I experience pain or discomfort during the session, I will immediately inform my technician so that the treatment can be adjust to my level of comfort. I will not hold my technician responsible for any pain or discomfort I experience during or after the session.

_____ I understand that the services offered today are not a substitute for medical care.

_____ I understand that my technician is not qualified to diagnose, prescribe, or treat physical or mental illness.

_____ I have voluntarily elected to receive a cryotherapy treatment and the nature and purpose of this treatment has been explained to me.

_____ I affirm that I have notified my technician of all known medical conditions and injuries.

_____ I affirm that I have properly hydrated as advised by my technician prior to my appointment

_____ I recognize there are no guaranteed results and that independent results are dependent upon age, skin condition, and lifestyle, and that there is a possibility I may require further treatments of the treated areas to obtain the expected results at an additional cost.

_____ I agree to inform the technician of any changes in my health and medical condition. I understand that there shall be no liability on the technician's part should I forget to do so.

_____ I understand that I may experience numbness or tingling, temporary skin discoloration, or ice burn in the area treated, but these side effects are normal and generally subside within a few hours.

_____ I understand there are no refunds for this treatment.

_____ I have disclosed any surgical procedures, implants, laser treatments, or facial procedures that I have had or intend on having in the future.

_____ To achieve maximum results, I understand diet and regular exercise will assist to sustain and create accumulative degree of overall spot fat reduction and body contouring.

_____ I have, to the best of my knowledge, given an accurate account of my medical history, including all known allergies or prescription drugs or products I am currently ingesting or using topically.

The client agrees to keep and obey all rules and regulations now in force or in the future assigned by Wave Wellness and Wave Wellness reserves the right to revoke this agreement for cause if the patron fails to keep and obey any such rules and regulations.

I have read and fully understand this agreement and all information detailed above. The information provided has been explained to me and all my questions have been answered to my satisfaction. I understand the procedure, accept the risks, and consent to have the treatment done. I agree I will assume the risk and full responsibility for any and all injuries, losses, side effects, or damages that might occur to me while I am undergoing this procedure. I do not hold the technician responsible for any of my conditions that were present, but not disclosed at the time of this procedure, which may be affected by the treatment performed today.

Client Signature _____ Date _____

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