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WELLNESS

LIGHT THERAPY CUSTOMER INTAKE FORM

Name: _____

Address: _____ City: _____ Zip: _____

Phone (H): _____ (C): _____ (W): _____

Date of Birth: _____ Email Address: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY:

Have you used Light Therapy before? Yes No

What is your goal in using Light Therapy? _____

_____

Are you taking any prescription medications? Yes No

If Yes, please list them _____

_____

Have you ever had an allergic reaction to sunlight? Yes No

Circle any that apply to your present condition -

Epilepsy Pregnant Cancer Eye/vision problems Accutane or similar medication

List any current medical conditions_____

_____

_____
Customer Initials

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

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SAUNA CONSENT FORM

Wave Wellness use is by appointment only. Please call to schedule an appointment. Consent to use the far infrared sauna is conditional upon provision of accurate answers to the following questions and to signing this agreement.

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (Home/Cell): _____ Email: _____

How did you hear about us? (List name of person if referral.): _____

ANSWER THE FOLLOWING QUESTIONS BY CIRCLING YES OR NO:

Are you pregnant?	YES	NO
Are you taking any medications?	YES	NO
Have you had a recent heart attack?	YES	NO
Have you been diagnosed with Anhidrosis, unstable angina, or any other medical conditions?	YES	NO
• If yes, please list medical condition(s): _____		
If you answered "yes" to any of the above questions; have you consulted with your medical provider about using a far infrared sauna?	YES	NO

FULL SPECTRUM INFRARED SAUNA AGREEMENT/ ACKNOWLEDGEMENT

1. The use of drugs, medication, or alcohol prior to or during the sauna session may lead to dizziness or unconsciousness. Clients using medications must consult a physician/pharmacist prior to the use of the sauna.
2. Clients with a medical history of circulatory system problems should consult a physician prior to using the sauna.
3. Please consult your physician if you are in doubt of your ability to use the far infrared for health reasons.
4. No one under the age of 18 is permitted in the far infrared sauna unless accompanied by a supervising adult.
5. Discontinue the use of the sauna if you feel light-headed, dizzy, or heat exhausted.
6. Sauna sessions are limited to 60 minutes and temperatures must stay below 160 degrees Fahrenheit.
7. Drink plenty of water before and after your sauna session. Plastic water bottles are not permitted in the sauna.
8. Pregnant women should not use the sauna.

I acknowledge and accept the risks inherent in the use of the Wave Wellness sauna. I voluntarily assume the risk of injury, accident, or death which may arise from the use of the Wave Wellness sauna. I and any of my heirs, executors, representatives, or assigns hereby release from all claims or liabilities for personal injury or property damages of any kind sustained while on the premises, during the use of the Wave Wellness sauna and from any advice provided by an employee, independent contractor, or any representative. I have carefully read the above safety instructions for using the Wave Wellness sauna. I fully understand them and fully agree to comply with instructions. This agreement is in effect for all the Wave Wellness sauna sessions/ treatments and will not expire unless requested by either party.

Client Signature _____ Date _____

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LIGHT THERAPY CUSTOMER CONSENT FORM

Although every precaution will be taken to ensure your safety and well being before, during and after your Light Therapy treatment, please be aware of the following infomation and possible risks. Please initial:

___ I understand there are certain contraindications that would preclude me from receiving LED treatments, including epilepsy, medications causing light sensitivity, open wounds, and pregnancy.

___ I understand that reactions are rare, but may include nausea, dizziness, weakness, and possible skin reactions including redness and/or other irritations.

___ I understand that while the goal of this treatment is to improve the vitality of the skin, no specific guarantees of the result can or have been made.

___ I understand that I must come to all treatments without any products, deodorant, perfume or lotions on my skin.

___ I understand and agree to use recommended eye protection during my treatments.

___ I understand that additional conditions could occur or be discovered during the procedure which could affect my ability to tolerate the procedure.

I understand that if I have any concerns, I will address these with my skin care specialist. I give permission to my skin care specialist to perform the LED procedure we have discussed, and will hold him/her and his/her staff harmless and nameless from any liability that may result from this treatment. In the event I may have additional questions or concerns regarding my treatment, I will consult the skin care specialist immediately. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read, and fully understand, the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered. I understand the procedure and accept the risks. I do not hold the skin care specialist, whose signature appears below, 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 Name (Printed) _____

Client Name (Signature) _____Date:_____

Parent Signature (if under 18) _____

Skin care specialist_____

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