Complete the following for Infrared Sauna

Have you ever experienced an Infrared Sauna session? Yes☐ No☐ If yes, how long ago?:_____

Note: Use of an Infrared Sauna under any of these circumstances, is prohibited: (check all that apply)

- ☐ Adrenal suppression (body does not respond to heat)
- ☐ SLE (Systemic Lupus Erythematous)
- ☐ Multiple Sclerosis
- ☐ Hyperthyroidism
- ☐ Hemophilia
- ☐ If you are pregnant or are nursing.
- ☐ If you have acute joint injuries.
- ☐ If you have enclosed infections (dental, joints, tissue).
- ☐ With artificial joints, metal pins, or any other implants.
- ☐ During menstrual cycle, as it may increase menstrual flow.
- ☐ If you suffer from hemophilia or have other predispositions to bleeding.
- ☐ If you take a prescription drug, check with a physician or pharmacist for any possible change in drug's effect due to interaction with infrared energy.
- ☐ If you are heat intolerant and do not sweat even with vigorous exercise.

I have discussed the above checked contraindications, if any, with the therapist prior to use of the infrared sauna. I am aware adverse events such as heat stroke, have been alleged and claimed with the use of far infrared devices. I am responsible for my own self-treatment. If during a session I feel, weak, tired, nauseous, discomfort or pain, I am responsible for immediately stopping my session, exiting the booth and notifying the therapist.

By my signature below, I certify and affirm that I have listed all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile, and understand that there shall be no liability on the therapist's part should I fail to do so.

Atlanta Colonic and Massage does not claim to treat or cure any condition, illness or disease.

Cancellations and Rescheduling:

We at Atlanta Colonic & Massage understand that sometimes a client may need to cancel or reschedule an appointment. We do require a minimum of a 24-hour notice for cancellations or rescheduling of appointments, to ensure therapist and facilities availability, for other clients. **No call/No shows will be charged l00% of total services scheduled for that day.**

I have read and understand Atlanta Colonic & Massage's cancellation/rescheduling policy.

Client Printed Name: _____
Last *First* *MI*

Client Signature: _____ _____
(for clients under age of 18, signature of parent/legal guardian required) *Date*