

## fit Bodywrap™ Customer Release Form

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: **M / F** Height: \_\_\_\_\_ Occupation: \_\_\_\_\_

Current Type of Exercise: \_\_\_\_\_ Activity Level: Low - Moderate - High - Pro. Athlete

Have you ever used an infrared sauna or infrared body wrap? **Yes / No**

Reason for Visit, Motivations, and Expectations: \_\_\_\_\_

### Contra-Indications for Infrared Body Wrap (Please read carefully, and circle **ALL** that apply):

Cardiac Condition:	<b>Y / N</b>	Heavy Menstruation:	<b>Y / N</b>	Hyper/Hypo Thyroid:	<b>Y / N</b>
Lupus Erythematosus:	<b>Y / N</b>	Acute Joint Injury:	<b>Y / N</b>	Diabetes requiring Insulin:	<b>Y / N</b>
Adrenal Suppression:	<b>Y / N</b>	Implanted Pacemaker:	<b>Y / N</b>	Kidneys Malfunctions:	<b>Y / N</b>
Multiple Sclerosis:	<b>Y / N</b>	Pregnancy:	<b>Y / N</b>	Open Wounds:	<b>Y / N</b>
Metal Pins or Rods:	<b>Y / N</b>	Constricted Coronary Blood Vessels:	<b>Y / N</b>	Skin Diseases:	<b>Y / N</b>
Artificial Joints:	<b>Y / N</b>	High or Low Blood Pressure:	<b>Y / N</b>	Contact Allergies:	<b>Y / N</b>
Implanted Silicone:	<b>Y / N</b>	Enclosed Infection (Dental, Joint):	<b>Y / N</b>	Fever:	<b>Y / N</b>
Varicose Veins:	<b>Y / N</b>	Hemophilia:	<b>Y / N</b>	Severe General Infection:	<b>Y / N</b>

Other (Please Describe): \_\_\_\_\_

Consult your doctor before receiving an Infrared Body Wrap treatment if you have received treatment/care for any of the above listed conditions in the Contra-Indications area. You cannot receive the treatment if you suffer from any of the conditions described above or any other condition where the use of a infra-red heat treatment is contraindicated, **or if you are under the age of 18.**

If you have a history of any other medical condition, or you are taking prescription drugs, you should consult your physician before using an Infrared Body Wrap. **Before, during, and after a fit Bodywrap™ session it is imperative to stay hydrated by drinking plenty of fluids.**

Doctor's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Doctor's Approval: \_\_\_\_\_

I have been fully informed and understand the use of the fit Bodywrap system and accept personal responsibility for my treatments. I understand that **SUN ON THE RUN** and its staff are not liable for any injury to person caused in any way by the use of its services or premises. **I am aware that the results achieved by this treatment may vary from person to person, and I acknowledge that no promises or guarantees have been made to me as to the results of this treatment.**

Client Signature: \_\_\_\_\_

Date: \_\_\_\_\_