# Trinity Wellness
# Infrared Sauna Client Health + Consent Form

Name _____ DOB _____
Email _____ Phone # _____
Referred by _____
Emergency Contact Name/Phone # _____

I _____, (Client Name) understand that the infrared sauna benefits are intended to enhance my health & wellness. Instruction has been given to me about its use. I am aware of the risks associated, possible injuries &/or contraindications explained to me. I understand that it is not a substitute for medical treatment and that it is advised that I see my Primary Care Physician for any condition(s) that I may have. I am aware that the TW Staff does not diagnose illness or disease, prescribe medications, and only advises on wellness care. _____ (initials)

Please answer the following health/medical questions:

1) Are you currently suffering from any ailment that could be affected?
   Yes or No If yes, please explain: _____
2) Are you currently under a physician care for any health condition or ailment?
   Yes or No If yes, please explain: _____
3) The following are ***CONTRAINDICATIONS*** to Infrared Sauna use:
   a. pregnancy, hemophilia, fever, insensitivity to heat, alcohol consumption, pace maker, acute joint injury (48hrs), enclosed infections
4) The following are ***PRECAUTIONS*** to Infrared Sauna use:
   a. certain medications, children 6 yrs.younger (> sweat), elderly 80 yrs older (< sweat) & women on menstruation cycle (due to increased blood flow)
   b. implants such as metal, artificial joints, silicone or any other.
   c. conditions that are associated with impaired sweating such as Multiple Sclerosis, Parkinson's, & Diabetes with Neuropathy
   d. cardiovascular conditions (hypertension / hypo tension), congestive heart failure, impaired coronary circulation or medications which might affect blood pressure, should exercise extreme caution

I have informed the TW staff of any known medical condition(s) and medication(s). I understand that neither TRINITY WELLNESS nor the TW staff are held liable for any injuries nor responsible for the aggravation of any condition(s) or symptom(s) that were present but not disclosed at the time or any that may follow in the future. If there are any changes to my health, I will inform the TW staff member immediately _____ (initials)

Sign _____ Date _____