CRYOTHERAPY | WELLNESS

PHYSICAL READINESS QUESTIONNAIRE

Date _____

First Name _____ Last Name _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Home Phone _____ Cell Phone _____

Email _____ Sex: M _____ F _____

Emergency Contact _____

Contact Phone _____Contact Relationship _____

How did you hear about Core Cryotherapy? If referred by whom? _____

PLEASE READ CAREFULLY BEFORE SIGNING

This is a release of liability and a waiver of certain legal rights. Attached is a list of 'Contraindications' which preclude participation in all of our services. In addition, PLEASE BE AWARE, that if you experience any pain or mental/physical discomfort at any time during any of the services, you are advised to terminate the services immediately.

LIABILITY AND MEDICAL RELEASE AND INDEMNIFICATION AGREEMENT

In consideration of being permitted by CORE CRYOTHERAPY WELLNESS. to participate in any services, I hereby waive any and all claims and damages for personal injury or death which may occur as a result of my participation.

I understand and agree that:

1. In consideration for using the cryotherapy device (equipment) and other services, I hereby RELEASE, WAIVE, DISCHARGE, and HOLD CORE CRYOTHERAPY WELLNESS or any of its employees (hereinafter referred to as RELEASEE) from any and all liability, claims, demands, actions and causes of action whatsoever arising out of or related to any damage or injury that may be sustained by me, while using the equipment or due to the use of the equipment and services.

2. I hereby confirm that no warranty, guarantee, or other assurance has been made to me covering the results of all services. I have been explained to and understand the administration of all services, including possible adverse reactions, side effects, or other complications. It is understood that this CONSENT is being given in advance of any administration of the servies and is being given by me voluntarily to use the equipment.

3. I am fully aware of the risks connected with the use of the equipment and services. I am voluntarily participating in said services, equipment usage, and entering the above named premises to engage in such usage. I VOLUNTARILY ASSUME FULL RESPONSIBILITY FOR ANY RISKS that may be engaged in such an activity.

4. I further hereby AGREE TO INDEMNIFY AND HOLD HARMLESS the RELEASEE from any costs that may incur due to the use of equipment by me.

5. It is my express intent that this Release and Hold Harmless Agreement shall bind the members of my family and shall be deemed as a RELEASE, WAIVER, AND DISCHARGE of the above named RELEASEE. I hereby further agree that this Waiver of Liability and Hold Harmless Agreement shall be construed in accordance with the laws of the State of Mississippi.

6. I understand that the equipment is designed for fitness and appearance enhancing use only by persons in good general health. I have been advised that if I suffer from any medical condition or illness whatsoever, I am NOT TO USE the services or the equipment without my doctor's written permission.

Please answer these following questions as accurately as possible

1. Are you in good health at the present time to the best of your knowledge? **YES NO**

   If not, please specify: _____

2. Are you under a doctor's care at the present time? **YES NO**

   If yes, for what?_____

   Doctor's name:_____

3. Are you allergic to anything, medications included? **YES NO**

   If yes, what?_____

4. Have you had any serious injuries in the past year? **YES NO**

   Please Specify:_____

5. Have you had any surgeries in the past year? **YES NO** Please Specify:_____

6. Please list any medications you are taking_____

   _____

Please answer the following questions:

QUESTION	YES	NO
1. Do you smoke?		
2. Do you drink alcohol?		
3. Do you exercise regularly?		
If yes, how long (minutes)? How often?		
4. Do you consider yourself having a healthy diet?		
5. How much water do you drink per day? # of glasses_____		
6. Have you ever used an infrared sauna before?		
7. Diagnosed with any medical condition, such as Anhidrosis, that may limit or prevent your ability to sweat?		
8. Do you have unstable angina?		
9. Do you have severe arterial disease?		
10. Have you consulted with your medical provider about using a infrared sauna?		
11. Have you had a heart attack within the previous 6 months?		
12. Do you have a pacemaker or defibrillator?		
13. Have you had heart bypass surgery within the past 6 months?		
14. Do you have Congestive Heart Failure (CHF)?		
15. Do you have Chronic Obstructive Pulmonary disease (COPD)?		
16. Circulatory and other risk factors?		
17. Do you have Raynaud's disease (more than hands/feet sensitivity)?		
18. Are you allergic/sensitive to cold?		
19. Do you have an intrathecal pump (pain pump)?		
20. Do you have any open wound track or lesions?		
21. Are you pregnant?		

If you have answered YES to any of these questions, have you consulted with your healthcare physician about using our services? YES NO

FAMILY MEDICAL HISTORY FORM

YES	NO	YOU	FAMILY	CONDITION
				High Cholesterol
				Heart Disease, arrhythmia
				Diabetes
				High Blood Pressure
				Asthma
				Tuberculosis
				Rheumatic Fever
				Thyroid Disease
				Liver Disease
				Stomach Problems
				Gallbladder Problems
				AIDS/ HIV
				Breast Feeding Currently?
				Kidney Disease
				Glaucoma
				Breast Problems
				Blood Transfusion
				Cancer
				Birth defects
				Inherited Diseases
				Psychiatric Illness
				Nervous Breakdown
				Constipation/ Diarrhea
				Bowl Movement Issues
				Lung Disease
				Anemia
				Pneumonia
				GI Bleeding Disorder
				Gout
				Depression
				Chest Pain or Tightness
				Anxiety
				Pyelonephritis
				Stroke or TIA
				Swollen Ankles
				Osteoporosis
				Frequent Headaches
				Migraines
				Feet Swelling
				Seizure Disorder
				Insomnia
				Phlebitis

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My signature below constitutes my acknowledgment that (1) I have read, understand, and fully agree to the foregoing CONSENT, (2) I hereby give my authorization and consent and (3) received the contraindication information. This CONSENT shall stand as long as I use the equipment and services at the location now and in the future.

Furthermore, I agree that I will comply with all instructions on the use of all the equipment and that I am using these services at my own risk. I agree to use all sessions within the terms of the contract dates and understand that refunds are not given on unused portions of purchased packages.

_____	_____	_____
Printed Name	Signature	Date

PARENTAL CONSENT FORM FOR MINORS UNDER THE AGE OF 18

If under 18 years of age, parental consent is required. Please complete below for consent of a minor. Customers are required to be a minimum of 13 years of age for use of the whole-body cryotherapy chamber.

I, (Print name: Parent or Legal Guardian) _____ acknowledge that I have read and understand the CORE CRYOTHERAPY WELLNESS waiver acknowledgement of risk regarding ALL services offered.

My son/daughter (Print Minor's Name) _____ has also read and acknowledged the contraindications and waiver of risk. I give consent on behalf of my minor to voluntarily undergo services.

_____	_____	_____
Parent/Guardian Printed Name	Signature	Date

_____	_____	_____
Minor Printed Name	Signature	Date