

Infrared Sauna Intake Form

Please help us provide you with the most effective service by completing the following questions. All information is kept **confidential**.

Personal Data: (please print)

First Name _____ Last Name _____

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Email _____

Occupation _____ Date of Birth _____

Male _____ Female _____ Current Type of Exercise Routine _____

Have you ever used an Infrared Sauna? Yes _____ No _____

Reason for Visit, Motivations, Expectations _____

Emergency Contact _____ Number _____

A contraindication is an indication or symptom that makes it inadvisable to use a particular therapy. The following are contradictions for colon hydrotherapy. If any of these apply to you we are not able to treat you at this time. Once these contradictions have subsided, been eliminated, or you are under the supervision of a doctor (prescription needed) we will be able to treat you. Please check the appropriate boxes.

- Yes No Adrenal Suppression
- Yes No Acute Joint Injury 1st 48 hours
- Yes No Artificial Joints
- Yes No Cancer
- Yes No Cardiac Condition
- Yes No Constricted Coronary Blood Pressure
- Yes No Enclosed Infections (Dental, Joint)
- Yes No Pregnancy & Nursing Mothers
- Yes No Severe General Infection
- Yes No Lupus Erythematosus
- Yes No Heavy Menstruation
- Yes No Phlebitis and/or Thrombo-phlebitis

- Yes No Implanted Pacemaker
- Yes No Multiple Sclerosis
- Yes No High or Low Blood Pressure
- Yes No Metal Pins or Rods
- Yes No Hemophilia
- Yes No Over-Active-Thyroid Gland
- Yes No Insulin-Dependent Diabetes
- Yes No Kidney Malfunctions
- Yes No Open Wounds, Skin Diseases & Contact Allergies
- Yes No Fever

I have read and agree to the policies of THE PIPER CENTER *for Internal Wellness*

- Please be on time. If you are late, a shortened session will be charged at the full rate.
- We request payment in full at the time of your visit. We accept cash, Visa, MasterCard and personal checks.
- A referral from your primary health care provider or our supervising physician is required if you a condition or are following a prescribed treatment.
- We require 24 hours notice for all cancellations or postponements: otherwise you will be charged the full session. As a courtesy, we give clients a telephone reminder a day or two before an appointment.
- All series must be used within 1 year. No refunds are given after the 1 year expiration date.
- I understand that the therapist does not diagnose illness, disease, or any other physical or mental disorder. The therapist does not prescribe medical treatment or pharmaceuticals. It has been explained to me that colon therapy is not a cure or substitute for a medical examination, treatment or diagnosis. It is recommended that I see physician for any ailments that I might have. All information that I provided is correct to the best of my knowledge. If any health issues arise, I agree to inform my therapist.

Thank you for choosing THE PIPER CENTER *for Internal Wellness* for your alternative medical care. We look forward to working with you in your journey toward Health Inside and Out.

Client Signature _____ Date: _____