FORMOSTAR
INFRARED BODY WRAP

# Customer Data Sheet

Last Name: _____ First Name: _____

Address: _____ City: _____ Zip: _____

Home Telephone: _____ Business Telephone: _____

# of Treatments Booked: _____ Date of 1st Treatment: _____

Date of Birth: _____ Female _____ Male _____ Height without Shoes _____

Occupation: _____ Current Type of Exercise Routine: _____

Have you ever used an Infrared Sauna or Body Wrap: Yes _____ No _____

Reason for Visit, motivation, expectations _____

## Contra-Indications for Infrared Body Wrap

| | | | |
|---|---|---|---|
| **Cardiac Condition** | ( ) | **Constricted Coronary Blood Vessels** | ( ) |
| **Lupus Erythematosus** | ( ) | **High & Low Blood Pressure** | ( ) |
| **Adrenal Suppression** | ( ) | **Enclosed Infections (Dental, Joint)** | ( ) |
| **Multiple Sclerosis** | ( ) | **Hemophilia** | ( ) |
| **Metal Pins or Rods** | ( ) | **Overactive Thyroid Gland** | ( ) |
| **Artificial Joints** | ( ) | **Diabetes Requiring Insulin** | ( ) |
| **Implanted Silicone** | ( ) | **Kidney Malfunctions** | ( ) |
| **Varicose Veins** | ( ) | **Open Wounds** | ( ) |
| **Heavy Menstruation** | ( ) | **Skin Diseases** | ( ) |
| **Acute Joint Injury 1st 48 hrs.** | ( ) | **Contact Allergies** | ( ) |
| **Implanted Pacemaker** | ( ) | **Fever** | ( ) |
| **Pregnancy** | ( ) | **Severe General Infection** | ( ) |

Other please describe: _____

Consult your doctor before receiving an Infrared Body Wrap treatment if you have received treatment for any of the above listed conditions in the highlighted area. You can not receive the treatment if you suffer from any of the remaining conditions described above. If you have a history of any other medical condition or you are taking prescription drugs, you should consult your physician before using the Formostar Infrared Body Wrap.

Doctors Name: _____ Telephone #: _____

Doctors Approval: Written ( ) Verbal ( )

I have been fully informed and understand the use of the Formostar Encore Body Wrap System and accept personal responsibility for my treatments. I understand that _____ and its staff are not liable for any injury to person caused in any way by the use of its services or premises. I hereby authorize _____ to take photographs of me to use them as an aid in my treatment. 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: _____

* You are advised to use the restroom prior to the treatment