**Medical History Form**

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| --- | --- | --- | --- | --- | --- |
| Date: |  | |  | Date of Birth |  |
| First Name: | |  |  | Last Name: |  |
| Address: | |  |  | City: |  |
| Zip: | |  |  | State: |  |
| Phone: | |  |  | Email: |  |

**NOTE: There is a weight limit of 350lbs.**

Contraindications acknowledgment:

* Are you currently taking any medications? (Including any vitamins or supplements)

If so, please list:

|  |  |  |
| --- | --- | --- |
|  |  |  |
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Severe Cardiovascular Conditions

* Do you have untreated Hypertension? Yes \_\_ No \_\_
* Do you have Peripheral Arterial Occlusive Disease? Yes \_\_ No \_\_
* Have you had a heart attack within the previous 6 months? Yes \_\_ No \_\_
* Do you have Valvular heart disease? Yes \_\_ No \_\_
* Do you have Unstable Angina Pectoris? Yes \_\_ No \_\_
* Do you have Ischemic heart disease? Yes \_\_ No \_\_
* Do you have any heart surgery conditions? Yes \_\_ No \_\_
* Do you have a pacemaker? Yes \_\_ No \_\_
* Do you have decompensating diseases (edema) of the cardiovascular and respiratory system, congestive heart failure, COPD, or chronic liver disease? Yes \_\_ No \_\_

Circulatory/Skin Conditions

* Do you have Deep Vein Thrombosis (DVT) or a known circulatory
* dysfunction? Yes \_\_ No \_\_
* Do you have Raynaud's disease? Yes \_\_ No \_\_
* Do you have bacterial or viral infections of the skin, wound healing disorders
* (open sores or discharging wound/skin conditions)? Yes \_\_ No \_\_
* Do you have Vasculitis? Yes \_\_ No \_\_

Blood Disorders

* Do you have severe anemia? Yes \_\_ No \_\_
* Do you have consumerist diseases (abnormal bleeding)? Yes \_\_ No \_\_

Conditions of the Nervous System / Kidney & Liver function

* Do you have diabetes? Yes \_\_ No \_\_
* Do you have acute kidney or urinary tract diseases? Yes \_\_ No \_\_
* Do you have any seizure disorders? Yes \_\_ No \_\_
* Do you have Hyperhidrosis - heavy perspiration? Yes \_\_ No \_\_
* Do you have Polyneuropathies? Yes \_\_ No \_\_

Other General Health Conditions

* Do you have acute febrile respiratory (Flu like respiratory conditions)? Yes \_\_ No \_\_
* Are you claustrophobic? Yes \_\_ No \_\_
* Do you have Cold Allergenic Phenomenon
* (known allergy to cold contactants)? Yes \_\_ No \_\_
* Do you have any alcohol or drugs related contraindications? Yes \_\_ No \_\_
* Are you Pregnant? Yes \_\_ No \_\_
* Are you currently receiving Physical Therapy Yes \_\_ No \_\_

If yes, check all that apply:

|  |  |
| --- | --- |
| \_\_ | Lower back pain |
| \_\_ | Spinal disc problems |
| \_\_ | Major joint dislocation |
| \_\_ | Cartilage or tendon tear |
| \_\_ | Arthritis or Bursitis |
| \_\_ | Ligament strain |
| \_\_ | Overuse condition of the knee, shoulder, hip, elbow or other joint |

Please tell us what piqued your interest in cryotherapy and what your expectations are for the

treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**IN SIGNING THIS RELEASE, I ACKNOWLEDGE AND REPRESENT THAT** I have read and understand the foregoing and the proposed cryotherapy process has been satisfactorily explained to me and I have all of the information I desire. I am at least eighteen (18) years of age and fully competent; and I execute this document for full, adequate, and complete consideration fully intending to be bound by same. Furthermore, I agree that I will comply with all instructions on the use of the cryosauna and that I am using these services at my own risk.

**I HAVE READ ALL OF THE CRYOSAUNA FACTS AND RISKS PROVIDED BY SPORTS RECOVERY LAB. I AM AWARE OF THE ABSOLUTE CONTRAINDICATIONS AND TREATMENT REQUIREMENTS INVOLVING THE CRYOTHERAPY.**

**I AM AWARE THAT THIS IS A RELEASE OF LIABILITY AND A POTENTIAL CONFLICT BETWEEN MYSELF, AND MY HEIRS AND CRYOGENESIS. I VOLUNTARILY AGREE TO EACH OF THE TERMS AND PROVISIONS HEREIN AND SIGN THIS OF MY OWN FREE WILL.**

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|  |
| Printed Name |
|  |
| Signature |
|  |
| Date (mm/dd/yyyy) |
|  |
| Participant / Parent or Legal Guardian Signature |