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 O Male O Height without Shoes ________

Occupation ______________ Current type of Exercise ______________________

Have you ever used an Infrared Sauna or Body Wrap? O Yes O No

Reason for Visit, Motivations & Expectations ______________________

CONTRA-INDICATIONS FOR INFRARED BODY WRAP

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

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 cannot 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 Infrared Body Wrap.

Doctor's Name ______________________ Phone # ______________

Doctor's Approval: Written O Verbal O

I have been fully informed and understand the use of Formostar Body Wrap System and accept personal responsibility for my treatments. I understand that SALON NAME HERE 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 SALON NAME HERE to take photographs of me and 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 procedure.