

CUSTOMER DATA SHEET



Full Name _____ Male/Female: _____ Phone/Cell _____

Address _____ City/State _____

of Treatments Booked _____ Date of 1st Treatment _____ Date of Birth _____

Occupation _____ Height (without Shoes) _____ Current type of Exercise _____

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

Contra-indications for Infrared Body Wrap (please check all that apply):

You cannot receive the treatment if you suffer from any of the conditions described below.

- Acute Joint Injury (1st 48 Hrs) _____
- Diabetes requiring Insulino _____
- Implanted Pacemaker _____
- Kidneys Malfunctions _____
- Pregnancy _____
- Open Wounds _____
- Constricted Coronary Blood Vessels _____
- Skin Diseases _____
- High or Low Blood Pressure _____
- Contact Allergies _____
- Enclosed Infection (Dental, Joint) _____
- Fever _____
- Hemophilia _____
- Overactive Thyroid Gland _____
- Severe General Infection _____

If you have a history of any other medical condition, including allergy to plankton, iodine and products from the ocean, or you are taking prescription drugs, you should consult your physician before using the Sudatonic Infrared Body Wrap.

Doctor's Name _____
Phone # _____
Doctor's Approval: _____
Written _____
Verbal _____

Consult your doctor before receiving a Sudatonic Infrared Body Wrap treatment if you have received treatment for any of the listed conditions below.

- Cardiac Condition _____
- Heavy Menstruation _____
- Varicose Veins _____
- Lupus Erythematosus _____
- Metal Pins or Rods _____
- Multiple Sclerosis _____
- Artificial Joints _____
- Implanted Silicone _____
- Adrenal Suppression _____
- Other (Please Describe) _____

Reason for Visit, Motivations & Expectations:

I have been fully informed and understand the use of Sudatonic Body Wrap System and accept personal responsibility for my treatments. I understand that KerryMassage and their staff are not liable for any injury to person caused in any way by the use of its services or premises. I hereby authorize KerryMassage 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.