

## Client Details Form

In accordance with our local Health Board we are obliged to keep client details.

(Please print clearly - *\*Indicates Required Field*)

\*First Name: \_\_\_\_\_ \*Last Name: \_\_\_\_\_

Birthday: \_\_\_\_\_ (*Month and Day – You get loyalty points on your B-day!*)

Street Address: \_\_\_\_\_ Suite # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ \*Zip Code: \_\_\_\_\_

\*Phone No: (\_\_\_\_\_) \_\_\_\_\_ (Please circle) Home Cell Office

E-mail: \_\_\_\_\_ (*Used for appointments, receipts, newsletter*)

Please initial the following;

\_\_\_\_ I hereby confirm that I am using the flotation facilities at my own risk. I further understand that while using the flotation facilities I could fall due to slippery surfaces resulting in severe injury, paralysis, brain damage or death.

\_\_\_\_ I hereby confirm and understand that Flotation Therapy can cause intense relaxation and it could influence motor skills and the ability to drive heavy machinery. Upon exiting the Float Therapy Spa I take all responsibility for my actions.

\_\_\_\_ I am not taking prescription medicine OR alternatively I have consulted my Doctor about Flotation Therapy and understand all associated risks in combination with my medication.

\_\_\_\_ I am not wearing a pacemaker and do not have any serious heart disease OR alternatively I have consulted my Doctor and understand all associated risks of Flotation Therapy in combination with my specific medical conditions.

\_\_\_\_ I do not suffer from epilepsy, psychotic attacks, respiratory, kidney or communicable disease. In rare cases Flotation causes nausea, vomiting, dizziness, and rashes. These could be a sign of a Kidney disorder and an inability to process magnesium. Should these symptoms occur please stop use of the Float Pod and consult your Doctor.

\_\_\_\_ I am not under the influence of drugs, alcohol or illegal substances.

\_\_\_\_ I have no history of ear infections OR alternatively I understand all risks associated with Flotation Therapy and my condition.

\_\_\_\_ I understand that the Float Pod contains 10 inches of water and could cause drowning or injury.

\_\_\_\_ I will pay a cleaning fee of \$500 on the day of incident should I voluntarily or involuntarily have a bowel movement, urinate or discharge any other fluid in the REST Pod. (*Women on their menstrual cycle must reschedule. There will be no penalty*)

Signed: \_\_\_\_\_

Date \_\_/\_\_/\_\_

How did you hear about us? (Please check the one that applies)

Facebook     Web Search (keyword) \_\_\_\_\_     Groupon     Yelp

Scottsdale Health Mag.     *other* Direct Mail     Meetup Group     Walk-In

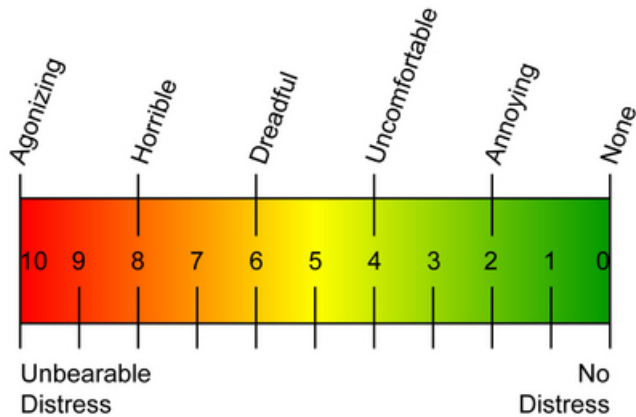
Gift Cert     Brochure     Radio \_\_\_\_\_ (what station or program?)

Other \_\_\_\_\_ (Details)     Referral – Who referred you? \_\_\_\_\_

Home & Garden Show

## PAIN

How much pain are you experiencing currently (1 to 10)



Is there a specific injury or condition causing this pain? (circle one) Yes / No

If so, what are the details?

---

---

## STRESS

- 10  Significant stress, Losing it!
- 8  A lot of stress, overwhelmed and depressed
- 6  Stress evident, feeling a little overwhelmed
- 4  Noticeable stress, but manageable
- 2  A little stress, but still feel good
- 0  No Stress, feeling wonderful

Using the following scale,  
what is your stress level?  
(1 to 10) \_\_\_\_\_

## SLEEP PROBLEM

Check all that apply:

- Problem Sleeping (perhaps reliant on sleep medicine)
- Overactive mind
- Lack of sleep