CRYOne

CLIENT INTAKE FORM

NAME:____________________________________DATE OF BIRTH:______________

ADDRESS:____CITY___________ZIP____________

E-MAIL:____(for specials, etc)

PHONE(s): H-_____________________________W-__________________________CELL:_____________

REFERRED BY:____

IN CASE OF EMERGENCY:____PHONE:__________

GENERAL INFORMATION:

YES NO

____ _____ Have you ever had a professional massage session? If yes, how long ago: _
____ _____ Do you experience frequent headaches? Migraines?________
____ _____ Do you have sinus or allergy trouble?
____ ____ Are you pregnant? What month?__________
____ ____ Are you a diabetic? When was your last shot?_________________Where?_______
____ _____ Do you have high blood pressure? Corrected by medication?__________________
____ _____ Do you suffer from active seizure disorder?
____ _____Are you HIV positive? ,
____ _____ Do you have or had cancer? hi remission since:______________________________
____ _____ Do you experience impotence or infertility?
____ _____ Are you currently taking any pain medication? For what?_____________________________
____ _____ Do you have high cholesterol?
____ _____ Do you experience frequent or slow urination?

DO YOU HAVE PROBLEMS WITH:
Chronic back pain___ Heel pain___ Planter Fasciitis___ Claw or hammer toes___
Neck pain___ Fallen arches___ Bunions___ Knee Pain___ Tennis or Golfers elbow___ Fibromayalgia___
Groin problems___ Carpal Tunnel Syndrome___ Tendinitis___ Thoracic Outlet Syndrome___

IN THIS SECTION, PLEASE ANY YES ANSWERS AS CLEARLY AS POSSIBLE: YES NO

___ ___Have you had surgery within 6 months?_______________________________________
___ ___ Have you had any broken bones?____
___ ___ Do you have cardiac or circulatory problems?____________
___ ___ Do you have numbness or stabbing pains anywhere?
___ ___ Are you sensitive to touch/pressure in any area?_________
___ ___ Do you have any other medical condition I should be aware of?

How do you like your Pressure

Light Med Deep

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HOW TO RECEIVE MASSAGE:

The best way to receive massage is fully nude; therefore all muscles receive full benefit. ALL JEWELRY SHOULD BE REMOVED FOR MAXIMUM RESULTS. Abdomen, pectoralis, as well as ribs will be massaged however breasts are only massaged with written and verbal consent (see below). Range-of-motion (stretching) on all limbs will be administered unless otherwise instructed by client. Draping choices are: single towel drape, or full sheet. These will be explained prior to session. Breathe in slowly thru your nose and exhale out your mouth for better relaxation.

How to Receive Ozone:

Ozone, or "activated oxygen", is introduced into a special steam sauna cabinet, where it then is absorbed thru the skin of the occupant. The result is a health effect on the occupant that combines the beneficial oxygenation and detoxification effects of both Ozone Therapy and Steam Sauna Therapy. Some reported effects of Oxygen Chamber Therapy are:

Dramatically increase oxygenation of the tissues and cells, Increase the White Blood Cell count , Increase circulation, oxygen and nutrient delivery within the body, Burn 400-600 calories per session!, Increase tumor necrosis factor by up to 500 times ,Purge the body of accumulated toxins such as pesticides, PCBs, drug residues, acidic wastes and much more, Stimulate the Immune System, Boost cellular mediated immunity (part of the immune system) , Produce Interleukin II, Gamma interferon (anti-cancer substances) ,Increase 2,3,DPG – this is responsible for the blood's ability to release oxygen in your tissues, Increase the dispensability (or "squish ability") of the Red Blood Cell so that it can squeeze through your tiny blood vessels into tissues

CRYOne, does not make nor infer any medical claims about the uses of our oxygen, ozone or other products for any medical condition, application or situation. Any type of massage, Cryo Therapy, Ozone Therapy is intended for therapeutic manipulation of muscle Tissue & Detoxing of the Body. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my comfort level. I also understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness and noting said in the course of the session(s) given should be construed as such.

Because massage is contraindicated (should not be done) under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all medical questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I forget to do so.

SIGNED:____

DATE: __________

ALL MASSAGES AND PACKAGES ARE NON REFUNDABLE AFTER THE FIRST SESSION IS COMPLETED.

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THE FOLLOWING IS TO BE SIGNED ONLY IF BREAST MASSAGE AND/OR BREAST LYMPHATIC DRAINAGE IS TO BE INCLUDED IN YOUR SESSION,

I, ____do hereby consent Kristen Bennett to perform clinical breast work on my body. I also understand sessions that follow, verbal permission, from me, will be received prior to continued breast therapy.