
Today's Date:_____

Name:_____ Date of Birth:_____

Address:_____ City:_____ Zip:_____

Phone:_____ Email:_____

Contraindication acknowledgement:

Are you currently taking any medications that may act adversely to whole body Cryotherapy? If so, please list:

_____

_____

Questions: Please check Yes/No

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 past 6 months? Yes_____ No_____
- Do you have Valvular heart Disease? Yes_____ No_____
- Do you have any cerebral or abdominal clips? 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 other Circulatory dysfunction? Yes_____ No_____
- Do you have Raynaud's Disease? Yes_____ No_____
- Do you have bacterial or viral infections of the skin, (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 conditions)? Yes_____ No_____
- Are you claustrophobic? Yes_____ No_____
- Do you have cold urticaria? Yes_____ No_____
- Do you have any alcohol or drug related contraindications? Yes_____ No_____
- Are you Pregnant? Yes_____ No_____

What is the reason for using Cryosauna Whole Body Cryotherapy?

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
Other: _____
_____

How did you hear about Denver Sports Recovery?
Search engine _____ Referral: _____ News Article _____ Doctor Referral _____

**IN SIGNING THIS RELEASE, I ACKNOWLEDGE AND REPRESENT THAT** I have read and understand the foregoing and the proposed cryothereapy 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 cryosauna and that I am using these services at my own risk.

**I AM AWARE THAT THIS IS A RELEASE OF LIABILITY AND POTENTIAL 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.**

_____

Printed Name

_____

Signature

_____

Date (mm/dd/yyyy)

_____

Participant/Parent or Legal Guardian Signature

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*Office use only

Initial BP:_____

Technician Initials:_____