THE BODY OF KENT

EST. 2024

SAUNA BLANKET CONSENT FORM

Customer Name:

Email Address:

Address:

Contact Number:

Procedure(s):

Confidential Medical History Questionnaire

Answer YES or NO to the following questions; if YES , give more details overleaf. If you do not understand any of the question please ask a member of staff.

Do you have a history of Cancer and undergone radiotherapy or chemotherapy in the past 5 years? ◯ Yes ◯ No

Are you taking or have taken steroids/cortisone in the past 12 months? ◯ Yes ◯ No

Are you allergic to any materials or products used? ◯ Yes ◯ No

Do you have a pacemaker or suffered heart conditions in the past? ◯ Yes ◯ No

Are you suffering from any form of liver disease? ◯ Yes ◯ No

Are you suffering from or had fibrosis, Hepatitis all forms? ◯ Yes ◯ No

Are you recovering from an operation within the last 6 weeks? ◯ Yes ◯ No

Are you diagnosed with any long-term medical conditions? ◯ Yes ◯ No

Are you suffering from osteoarthritis? ◯ Yes ◯ No

Are you pregnant or breast feeding? ◯ Yes ◯ No

Have you had acne treatment Ro-accutane within the past 6 months? ◯ Yes ◯ No

Are you Diabetic? ◯ Yes ◯ No

Do you have kidney disease? ◯ Yes ◯ No

Do you suffer from thyroid disorders? ◯ Yes ◯ No

Do you suffer from Epilepsy? ◯ Yes ◯ No

Are you on any blood thinning medication? ◯ Yes ◯ No

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TREATMENT RESTRICTIONS

Treatment Restrictions

(This may limit or restrict the treatment)

Consult with a medical practitioner if you have a medical or other condition listed below.

Do you suffer from any skin conditions or diseases? (Eczema, Psoriasis etc)	◯ Yes	◯ No
Do you have sensitivity to heat/ temperature?	◯ Yes	◯ No
Do you have heart disease or illness?	◯ Yes	◯ No
Do you have any broken bones?	◯ Yes	◯ No
Have you recently had surgery?	◯ Yes	◯ No
Do you feel nauseous or have a headache?	◯ Yes	◯ No
Do you suffer with Splanchnic disease?	◯ Yes	◯ No
Do you have Osteoporosis?	◯ Yes	◯ No
Do you suffer from abnormal blood pressure?	◯ Yes	◯ No
Are you currently pregnant or breastfeeding?	◯ Yes	◯ No
Do you have Anhidrosis?	◯ Yes	◯ No
Do you have a history of Cancer and have undergone radiotherapy or chemotherapy in the past 5 years?	◯ Yes	◯ No
Do you have any metal or other body implants?	◯ Yes	◯ No
Do you have any medical conditions which you have not yet disclosed?	◯ Yes	◯ No

Please give details if any boxes are ticked **"Yes"**

Client signature:

Therapist signature:

Date: