Far Infrared Sauna Intake Form

Personal Information

Today's Date		
Name		
Address		
City	State	ZIP
Home Phone		Date of Birth
Cell Phone	Work Phone	
E-mail		

How did you hear about us? ☐ Friend ☐ Health Professional ☐ Patient ☐ Newspaper ☐ Magazine ☐ Other
Who may we thank for referring you?
Who is responsible for this account?

Medical History

Are you currently under medical care? ☐ yes ☐ no

Physician or Healthcare provider's name	Phone
Please list all current medical condition(s)?	
Please list current medications, herbs or supplements.	
Have you recently been or are you now in pain?	
If yes, please state location(s) of pain:	If yes, please state severity of pain on a scale of 0 to 10 ____
List any known drug allergies ☐ Latex ☐ Other	
Are you pregnant? ☐ yes ☐ no	

Signature _____ Date _____