AIR 2

Medical History Form

Date: _____ Date of Birth _____

First Name: _____ Last Name: _____

Address: _____ City: _____

Zip: _____ State: _____

Phone: _____ Email: _____

NOTE: There is a weight limit of 350lbs.

Contraindications acknowledgment:

- Are you currently taking any medications? (Including any vitamins or supplements)
  If so, please list:

_____ _____

_____ _____

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 previous 6 months? Yes __ No __
- Do you have Valvular heart disease? 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 a known circulatory dysfunction? Yes __ No __
- Do you have Raynaud's disease? Yes __ No __
- Do you have bacterial or viral infections of the skin, wound healing disorders (open sores or discharging wound/skin conditions)? Yes __ No __
- Do you have Vasculitis? Yes __ No __

Blood Disorders

- Do you have severe anemia, or 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 respiratory conditions)? Yes __ No __
- Are you claustrophobic? Yes __ No __
- Do you have Cold Allergenic Phenomenon?
- (known allergy to cold contactants)? Yes __ No __
- Do you have any alcohol or drugs related contraindications? Yes __ No __
- Are you Pregnant? Yes __ No __
- Are you currently receiving Physical Therapy Yes __ No __

If yes, 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

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

I AM AWARE OF THE PRIMARY CRYOSAUNA FACTS AND RISKS. I AM AWARE OF THE EFFECTS AND OF THE ABSOLUTE CONTRAINDICATIONS AND TREATMENT REQUIREMENTS INVOLVING THE CRYOTHERAPY.

I AM AWARE THAT THIS IS A RELEASE OF LIABILITY AND A POTENTIAL CONFLICT BETWEEN MYSELF, AND MY HEIRS AND BAM/AIR RECOVERY 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