ILLUMINA HEALTH
CRYO & WELLNESS CENTER

New Patient Information

Name: _____ DOB: _____ Date: _____

Address: _____ State: _____ Zip: _____

Phone: _____E-mail: _____

How did you hear about us? _____

Primary Care Physician: _____Phone: (____)_____

Emergency Contact: _____Relation: _____Phone: (___)_____

List current medications and the respective doses: _____

_____

List any conditions you are currently under medical care for: _____

_____

List your desired healthcare **goals** or **concerns** according to **priority**

1._____

2._____

3._____

Stress Level: 0 1 2 3 4 5 6 7 8 9 10 **0= no stress 10 = very stressed**
Quality of Sleep 0 1 2 3 4 5 6 7 8 9 10 **0= poor 10=good**

Women ONLY (circle yes or no):
Are your periods regular? Yes no
Are you pregnant? yes no
Do you plan to become pregnant anytime soon? yes no
Menopause? yes no

Diet: Check all that apply:
__Special diet type name diet_____ Number of times you eat per day ( )
Amount of water/day_____
Do you have a history of: compulsive or binge eating ( ) eating disorder ( )
Do you consume: ( ) fast food ( ) artificial sweeteners ( ) organic food consistently

Activity: ( ) yes ( ) no ( ) weekly ( ) daily type: _____( )hours ( )minutes

Medical History

Check any of the following conditions that apply to you:

____High blood pressure (BP> 180/100 mm Hg)
____Cardiac pacemaker
____Recent heart attack
____Heart Disease
____Heart Failure
____Mitral Valve Prolapse
____Rheumatic Heart Disease
____Valve problems
____Chest Pain
____Angina pectoris
____Raynaud's Syndrome
____Anemia
____Shortness of breath
____ Asthma
____Pneumonia
____Tuberculosis
____ Eczema
____ Hot Flashes
____ Kidney Disease
____Rheumatoid Arthritis

____Joint Pain / Stiffness
____Osteoporosis
____Chronic Back Pain
____Headaches / Migraines
____Frequent Colds / Infections
____Symptomatic cardiovascular disease
____Arrhythmia
____Venereal disease
____Lung disorder
____Seizures
____Autoimmune Disease
____Cold allergy/sensitivity
____Mood Swings
____Depression
____Anxiety
____Anger/Irritability
____Memory Loss
____Restlessness/Insomnia/Sleep Disorder(circle)

____ Other _____

Do you have any other medical or psychological diagnoses or condition that have not been mentioned? (Please list) _____

_____

_____

WAIVER OF LIABILITY AND HOLD HARMLESS AGREEMENT

Whole Body and Local Cryotherapy, Pulse Electro Magnetic Field Therapy, Exercise with Oxygen Training and Therapy, Photon Genius, Low Light Laser Therapy, Compression Therapy

____1. My signature and initials constitutes my acknowledgment that (1) I have read, understand, and fully agree to the foregoing CONSENT, (2), I hereby give my authorization and consent. This CONSENT shall stand as long as I use the Equipment listed above at the location now and in the future.

____2. In consideration for using the therapeutic modalities, I bind the members of my family and spouse (if any), if I am alive, and my heirs, assignees and personal representative hereby RELEASE, WAIVE, DISCHARGE, and HOLD HARMLESS Illumina Health, LLC, its officers, servants, agents, employees and volunteers (hereinafter referred to as RELEASEES) from any and all liability, claims, demands, actions and causes of action whatsoever arising out of or related to any loss, damage, medical costs or injury, that may be sustained by any person, while using the equipment or due to the use of the equipment.

____3. I hereby confirm that no warranty or guarantee, or other assurance, has been made to me covering the results of the therapeutic modalities. I fully understand the administration of the process, including possible adverse reactions, side effects, or other possible complications. It is understood that this CONSENT is being given in advance of any administration of the process, and is being given by me voluntarily to use the Equipment.

____4. I am at least eighteen (18) years of age and fully competent; and I execute this Release 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 Therapeutic modalities and that I am using these services at my own risk. I agree to use all sessions within the terms of the contract dates and understand that refunds are not given on unused portions of purchased packages.

I understand that the therapeutic modalities are not a replacement for being under the care of a physician and I have fully disclosed all of my medical diagnosis and/or conditions. I understand I have been given the opportunity to ask any pertinent questions and have been informed that I have the option to consult with the doctor on staff.

_____ _____ _____

Printed Name Signature Date

_____

Participant Parent or Legal Guardian Signature