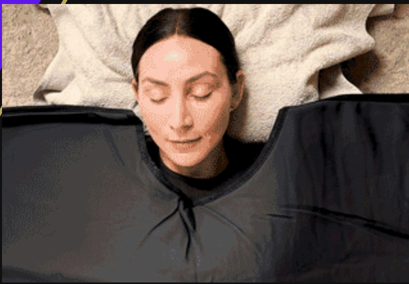

VIP FITNESS

CLIENT HEALTH ASSESSMENT

PLEASE ANSWER THE FOLLOWING QUESTIONS TO HELP US ASSESS YOUR SUITABILITY FOR INFRARED SAUNA THERAPY. YOUR RESPONSES WILL BE KEPT CONFIDENTIAL.

1. DO YOU HAVE ANY PRE-EXISTING MEDICAL CONDITIONS? (E.G., HEART DISEASE, HIGH BLOOD PRESSURE, DIABETES)

- YES / NO

IF YES, PLEASE SPECIFY: ____

2. ARE YOU CURRENTLY TAKING ANY MEDICATIONS?

- YES / NO

IF YES, PLEASE LIST: ____

3. HAVE YOU EVER EXPERIENCED HEAT-RELATED ILLNESSES (E.G., HEAT EXHAUSTION, HEAT STROKE)?

- YES / NO

4. DO YOU HAVE A HISTORY OF SKIN CONDITIONS OR SENSITIVITIES?

- YES / NO

IF YES, PLEASE SPECIFY: ____

5. ARE YOU PREGNANT OR TRYING TO BECOME PREGNANT?

- YES / NO

6. DO YOU SUFFER FROM ANY RESPIRATORY CONDITIONS (E.G., ASTHMA, COPD)?

- YES / NO

7. HAVE YOU HAD ANY SURGERIES OR MEDICAL PROCEDURES IN THE PAST YEAR?

- YES / NO

IF YES, PLEASE SPECIFY: ____

8. DO YOU EXPERIENCE ANY CHRONIC PAIN OR DISCOMFORT?

- YES / NO

IF YES, PLEASE SPECIFY: ____

9. DO YOU HAVE ANY ALLERGIES (E.G., TO HEAT, FABRICS, ESSENTIAL OILS)?

- YES / NO

IF YES, PLEASE LIST: ____

10. WHAT ARE YOUR PRIMARY WELLNESS GOALS FOR USING INFRARED SAUNA THERAPY? (E.G., RELAXATION, DETOXIFICATION, PAIN RELIEF)

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DISCLAIMER

The information provided in this questionnaire is for assessment purposes only and does not constitute medical advice. Infrared Sauna Therapy may not be suitable for everyone. This treatment is *not suitable for pregnant women*. If you have a heart condition, respiratory issues, or high blood pressure, it is advised that you seek medical advice prior to consenting to this treatment. By signing below, you acknowledge that you have disclosed accurate information to the best of your knowledge and understand the importance of consulting with a healthcare provider.

SIGNATURE:____________________________________

DATE: ___________________