INTAKE, CONSENT, and LIABILITY FORM

FULL NAME: ___________________________________ DOB: ____________________

EMAIL: __________________________________ CELL #: ______-______-________

Receive Emails: ☐ Receive SMS: ☐

HEIGHT: ____________

Who can we thank for referring you?______________________

Emergency Contact Information

Name: _________________________________ Relationship:__________________

Phone Number:__________________________

How can we help you? ____

Primary Reason You Are Here:

Chronic Pain__________ New Pain _________

Athletic Performance ________ Cognitive Health__________

General Health and Wellness __________ Post/Pre Operative ______

Date of injury: _____________________

Is the pain getting better _____ not changing ______ or getting worse_____

Have you been evaluated by a medical professional? _____________________________

If so who: General Doctor _______________________ Orthopedic_________________

Chiropractor ______________________________ Other__________________________

Pain Scale (10 being most painful)

1 2 3 4 5 6 7 8 9 10

Is it present always __________ or sometimes_________

What symptoms do you have today?_________________________________

Have you had any tests done? If so when? Xray __________ MRI _________ CT __________

Other____________________

Are you taking any medications for your condition? ________________________________

The following waiver, initialed areas (or check) & signatures constitute my representation, acknowledgment & agreement that I, ___________________________, read, understand, & fully agree to the following. This also applies to subsequent visits and treatments. I understand that there is no promise or guarantee regarding the results of the treatment, I understand there maybe risks, complications, increase soreness, and charges for these procedures (automatic with a credit card on file, Cash/Credit Cards only, No Health Insurance).

I hereby authorize and provide permission to perform:

PLEASE INITIAL ALL SERVICES

______Chiropractic Care including Examination, Manipulation, Active Release, Rehabilitation, and other recommended treatment

______ Aspen Class IV Laser Therapy treatment -Eye Safety - I understand that class IV therapy lasers emit both visible and invisible light. Protective eye wear is necessary at all times during treatment.

______ Theralight 360 Red Light Bed (up to 30 min)

______ Dahlia (20 min) red light -Circulation, Pain, Skin, Fat Loss

______ Normatech Compression Therapy

______ Hypermax O2 therapy (EWOT) NOsevere chronic lung disease (stage 2-3) or pregnancy.

______ Pulsed Electro Magnetic Field Therapy (PEMI or HUGO) NO electronic implants (e.g., pacemaker, implantable cardioverter defibrillator, cochlear implants), pregnancy, and ring-shaped metals in the body

______ Cryotherapy (3min on level 1,2,or 3)- I understand I am responsible to wear gloves, boots, our socks, and your underwear. I am responsible to keep my head out and above the unit. Plus make sure I am dry including undergarments and body. Take off jewelry. You must be at least 12 years old. Absolutely no heart conditions

______ Neufit Therapy (Rehab or workout) - NO people with pacemakers or other implanted medical devices, pregnant women

______ Massage Chair

______ Massage Therapy and Active Stretching- including hypervolt, CBD oils, oils, lotion, possible heat

______ E-stim, hot packs, cold packs

______ Health Coaching

______ HOCATT

______ Allcore 360

______ Shockwave

______ Acupuncture, Dry needling

______ Cupping, Taping, CBD and anything else we recommend

Patient Declaration:

I am aware that every safety measure will be undertaken by staff, and that this may include my refusal if deemed unsafe. The information that I have given is true and complete, and I would like to go ahead with using all equipment and treatments at my own risk. I understand what will occur during a session, treatments are not administered by a licensed medical professional. I take personal responsibility for my choice in receiving treatment or sessions. I shall not hold Champion Performance and Recovery OR Performance Wellness, the owners, the practitioners, or the technicians liable for anything including but not limited too: illness, injury or worsening of any conditioning that results from using any equipment, or doctors, therapists or technicians.

I have read all information, additional information and understand completely what I have read.

Patient and/ or Parent Name ____

Patient and/ or Parent Signature____

Date ____/____/______

WAIVER AND RELEASE AGREEMENT

PLEASE READ and ANSWER QUESTIONS CAREFULLY BEFORE SIGNING

Whole Body Cryotherapy

Do you have:

- Untreated Hypertension______ yes ______ no
- Heart attack within previous 6 months______ yes ______ no
- Decompensating diseases (edema) of the cardiovascular and respiratory ______ yes ______ no
- Congestive Heart Failure or COPD______ yes ______ no
- Chronic liver disease or Unstable Angina Pectoris______ yes ______ no
- Pacemaker______ yes ______ no
- Peripheral Arterial Occlusive Disease______ yes ______ no
- Deep Vein Thrombosis (DVT) or known circulatory dysfunction______ yes ______ no
- Acute febrile respiratory (Flu like respiratory conditions)______ yes ______ no
- Acute kidney and urinary tract diseases______ yes ______ no
- Severe Anemia______ yes ______ no
- Cold Allergenic Phenomenon (known allergy to cold contactants)______ yes ______ no
- Heavy consumerist diseases (abnormal bleeding)______ yes ______ no
- Seizure disorders______ yes ______ no
- Bacterial and viral infections of the skin______ yes ______ no
- Wound healing disorders (open sores or discharging wound/skin conditions)______ yes ______ no
- Alcohol and drugs abuse______ yes ______ no
- Valvular heart disease______ yes ______ no
- Recent heart surgery______ yes ______ no
- Ischemic heart disease______ yes ______ no
- Raynaud's disease______ yes ______ no
- Vasculitis______ yes ______ no
- Hyperhidrosis – heavy perspiration______ yes ______ no

IMPORTANT NOTICE: Whole Body Cryotherapy (WBC) is not an FDA approved medical treatment. It is not used to treat, cure or prevent any diseases. Rather it is used to assist the body in maximizing its innate self-healing abilities. Before trying WBC, you should always ask your medical professional if the treatment is safe and appropriate for you. WBC treatments are not administered by a licensed medical professional.

Risks of Whole Body Cryotherapy

Research has shown time and again that cryotherapy can be beneficial for your overall health. However, for its numerous benefits, you have to be aware of the risks associated with the treatment. Some of them include:

1. Burns: Exposure to extremely low temperatures can lead to frostbite and burns.
2. Dizziness and Fainting: Cryotherapy can cause dizziness and fainting due to the sudden drop in blood pressure. This can be dangerous, especially for individuals with pre-existing conditions such as low blood pressure or heart problems.
3. Lung Damage: Whole-body cryotherapy can cause lung damage, especially in individuals with pre-existing lung conditions such as asthma.
4. Allergic Reactions: Some individuals may have an allergic reaction to the nitrogen gas used in whole-body cryotherapy.
5. Eye Injuries: Eye injuries can occur when nitrogen gas is used in the therapy.

I understand I must avoid inhaling the nitrogen gas that is emitted into the chamber, I need to keep my head up (breathe in through my nose and out through my mouth) check this box ☐

If fainting occurs, do you want us to call an ambulance? __________yes __________ no

Staff Initials _________

I have read all information, additional information and understand completely what I have read.

Patient and/ or Parent Signature____

WAIVER AND RELEASE AGREEMENT

PLEASE READ and ANSWER QUESTIONS CAREFULLY BEFORE SIGNING

To the best of my knowledge:

Are you pregnant? ______ yes ______ no
Do you have cancer? ______ yes ______ no
Organ Transplant?______ yes ______ no
Do you have (severe) systemic infections lupus? ______ yes ______ no
Do you have Stage 2 Hypertension BP 160/100 and above?______ yes ______ no
Or Any other heart issues ________________________________
Do you have a pacemaker or other implanted devices? ______ yes ______ no
Do you have epilepsy and/or seizures? ______ yes ______ no

Explain if you answered yes to any of these questions:______________________________
____

LIABILITY AND MEDICAL RELEASE AND INDEMNIFICATION AGREEMENT

In consideration of being permitted by Champion Performance and Recovery and/or Performance Wellness to participate in their services, I hereby waive any and all claims and damages for personal injury or death which may occur as a result of my participation. I understand and agree that:

1. This release is intended to discharge in advance Champion Performance and Recovery and/or Performance Wellness, its officers, officials, employees, agents and volunteers from and against all liability arising out of or connected in any way with my participation in these activities;
2. Participation may involve risk of serious injury, illness, disability or death and may result not only as a result of my actions, negligence or inaction, but also from the action, negligence or inaction of others, including their owners, officers officials employees, or volunteers and may result from the conditions of the facilities, equipment, or areas where such activities are being conducted;
3. Knowing the risks involved and the contraindications related, I nevertheless chose voluntarily to request permission to participate;
4. I will indemnify and hold harmless Champion Performance and Recovery and/or Performance Wellness, its owners, officers, officials, employees and volunteers from any loss, liability, damage, cost or expense, including litigation of any form, arising out of or connected in any manner with my participation in such activities;
5. I am in good health and have no physical condition expressed in the 'Contraindications' or otherwise which would preclude me from safely participating in such activities;
6. I understand and agree that this release is intended to be as broad and inclusive as permitted under the law of the State in which it is executed and that if any portion of this Hold Harmless, Release and Indemnification Agreement should be determined to be invalid, it is my intent that the remaining provisions shall continue in full force and effect.

I HAVE CAREFULLY READ THIS RELEASE INDEMNIFICATION AND HOLD HARMLESS AGREEMENT AND FULLY UNDERSTAND ITS CONTENTS. I AM AWARE THAT THIS IS A RELEASE OF LIABILITY AND A POTENTIAL CONFLICT BETWEEN MYSELF, AND MY HEIRS AND CHAMPION PERFORMANCE AND RECOVERY AND/OR PERFORMANCE WELLNESS I VOLUNTARILY AGREE TO EACH OF THE TERMS AND PROVISIONS HEREIN AND SIGN THIS OF MY OWN FREE WILL

I have read all information, additional information and understand completely what I have read.

Patient and/ or Parent Name ____

Patient and/ or Parent Signature____

Date ____/____/______

LASER THERAPY CONSENT & CONTRAINDICATION FORM

Aspen Class IV Laser Therapy Treatment

I hereby authorize and provide permission to perform an Aspen Class IV Laser Therapy treatment.

- I understand that the Aspen Class IV Laser Therapy is a safe and non-invasive treatment and has been cleared by the FDA to emit photon energy for the relief of minor muscle and joint pain, muscle spasm, pain and stiffness associated with minor arthritis, promoting relaxation of muscle tissue, and increase local blood circulation.
- I understand that every individual responds uniquely to laser therapy treatments. Some patients may see immediate results after the first treatment or depending on the severity of their condition, may require several treatments before they begin to feel results. Most patients experience a decrease in pain and an increase in range of motion within the first few hours (and up to 36 hours) from the first treatment.

Note: Increased soreness may occur after your first laser therapy treatment session. This is a normal healing phenomenon known as retracing. If soreness occurs following your treatment, use ice for 5 minutes every 30 minutes, and no more than 5 minutes every 30 minutes. Repeat the icing as necessary. If soreness persists after icing, please contact this office.

CONTRAINDICATIONS:

To the best of my knowledge, I may have, or am, one or more of the following:

• Are you pregnant? _____Yes ____No

• Do you have cancer? _____Yes ____No

• Have you had cancer within the past 12 months? ___Yes ___No

• Are you currently taking photosensitizing medications? _____Yes _____No

• If yes, can you be in the sun for 10 min.without having itchiness, redness, blotchiness or pigmentation issues? ______Yes _____No

PRECAUTIONS:

To the best of my knowledge, I may have one or more of the following:

• Do you have a pacemaker or other implanted medical device (morphine pump,neurostimulator, etc)? _____Yes _____No

If yes, where is it located?

____

• Have you had steroid injection(s) within the past 7 days? ______Yes ______No

If yes, where?

____

• Is your pain directly over an epiphyseal plate (growth plate) in children under 15 years of age. ______Yes ______No

• Is your pain over the Ovaries,Thyroid Gland or Testes? _______Yes ______No

EYE SAFETY

I understand that Class IV Therapy Lasers emit both visible and invisible light. Protective eyewear is necessary at all times during the treatment. I will not remove the Safety Goggles until the administrator of the laser has turned off the laser treatment and provided notification that it is safe to remove them.

ACKNOWLEDGEMENT

I have read and understand the foregoing. This Laser Therapy Consent Form applies to subsequent visits and treatments. I understand that there is no promise or guarantee regarding the results of the treatment, and that to achieve maximum clinical results, I may need multiple treatments.

I have read all information, additional information and understand completely what I have read.

Patient and/ or Parent Signature____

Our Consultation Document, Liability and Consent

Performance Wellness and Champion Performance and Recovery

Massage Therapy ☐ Assisted Stretch ☐ Personal Training ☐

Massage therapy, Assisted Stretch, and Personal Training are not substitutes for medical examination or diagnosis. It is recommended that I see a physician for any physical ailment that I may have. I understand that the massage therapist does not prescribe medical treatments or pharmaceuticals and does not perform any spinal adjustments. I am aware that if I have any serious medical diagnosis, I must provide a physician's written consent prior to services.

Please check all that apply:

☐ Spinal Problems ☐ Migraines ☐ Smoke
☐ Varicose Veins ☐ High Blood Pressure ☐ Bruise Easily
☐ Allergies ☐ Heart Conditions ☐ Injuries
☐ Currently Pregnant? Due Date: ____________________

Please explain any checked above: ____

☐ Any medical conditions your therapist should be made aware of? _______________

____

Current Medications: ____

Areas of pain / tension: ____

Areas to be avoided: ____

The licensee shall drape the breasts of all female clients and not engage in breast massage of female clients unless the client gives written consent before each session involving breast massage.

Draping of the genital area and gluteal cleavage will be used at all times during the session for all clients.

The licensee must immediately end the massage session if a client initiates any verbal or physical contact that is sexual in nature.

If the client is uncomfortable for any reason, the client may ask the licensee to end the massage, and the licensee will end the session. The licensee also has a right to end the session if uncomfortable for any reason.

I have read all information, additional information and understand completely what I have read.

Patient and/ or Parent Name ____

Patient and/ or Parent Signature_______________________________________

Date ____/____/______

FORMAL WRITTEN CONSENT BY PARENT OR LEGAL GUARDIAN FOR MINOR CHILD

Additional Minor Family Members

Name: __________________________ Cell number: _______________ DOB:___________________

Name: __________________________ Cell number: _______________ DOB:___________________

Name: __________________________ Cell number: _______________ DOB:___________________

Name: __________________________ Cell number: _______________ DOB:___________________

Relationship _____________________

Minor Consent

Formal written consent by parent or legal guardian for above named minor child (under age 18) to use the whole-body cryotherapy chamber, chiropractic examination, manipulation, treatment, normatec compression, neufit, Aspen laser, Theralight 360 Red Light Bed, Dahlia, massage chair, masssage therapy, assisted stretch, ALLCore 360, Shockwave, EWOT, PEMF (Pemi or Hugo) or anything else Champion Performance and Recovery and/or Performance Wellness offers.

• I have completely read and understand each and every provision of the WAIVER, RELEASE of LIABILITY, CONSENT FORM, and HOLD HARMLESS AGREEMENT.

• I hereby give my full Parental or Guardian consent and permission for my minor child to participate in everything Champion Performance and Recovery and Performance Wellness offers.

I acknowledge, understand and represent that my minor child has growth plates and the laser

• I acknowledge, understand and represent that my minor child has attained the legal age of Twelve (12) years to do cryotherapy

• I understand that the cryotherapy treatment consists of spending a short period of time in an extremely cold environment and that I/my child are free to exit the chamber at any time we choose if we feel at all uncomfortable.

• I further understand that because of the extreme cold, nitrogen and the limited size of the Cryotherapy Chamber, I/My child may experience symptoms of claustrophobia, hyperventilation, skin irritation (including frostbite), fainting, and cold burn.

I have read all information, additional information and understand completely what I have read.

Patient and/ or Parent Name ____

Patient and/ or Parent Signature____

Date ____/____/______