

Float Intake Form

Welcome to



Our goal is to deliver the best experience possible. To customize your experience and exceed your expectations please complete the questions below.

Name: _____

Email: _____

Cell Phone: _____

Mailing Address: _____

Date of Birth: _____ Anniversary date _____

Occupation: _____ Referred by: _____

Preferred Method of Contact: Phone Email

Would you like Appointment Reminders sent to your Cell Phone? Yes or No

It is not advisable to engage in certain treatments where specific medical conditions exist.

Please review and check those conditions that have affected your health either recently or in the past. Place a check mark next to the conditions:

- | | | |
|--|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression, panic disorder, other psych condition | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Hepatitis (A, B, C, etc.) |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Broken/dislocated bones | <input type="checkbox"/> Heart conditions | <input type="checkbox"/> Skin Conditions |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Back Problems | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High/ Low blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Spinal Injuries | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Muscular Disorder | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> TMJ disorder | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Auto- Immune condition* |
| <input type="checkbox"/> Vertigo | | *AIDS, Lupus, Rheumatoid Arthritis, etc. |

If any of the above needs to be detailed or if there is anything not listed, please explain:

Float Intake Form

Do you have any allergies? (Cosmetics, ingredients, food, iodine, medications, latex, etc.)

No Yes (Please specify) _____

Are you currently undergoing chemotherapy or radiation therapy?

No Yes (Please specify) _____

Are you currently taking any medications, herbs, or vitamins? (Internal or Topically)

No Yes (Please specify) _____

Is there anything else we should know that may affect your treatment?

Other (Please specify) _____

Have you had or currently have any of the following within the last 5 days?

Skin rash Cold/Flu/ Open cuts Injuries/bruises
 Anything contagious Severe pain: _____

Women only Do any of the following pertain to you currently?

Hormonal Problems Pregnant Lactating
 Menopause Hormonal Birth Control Regular Menstruation

Are you currently wearing: contact lenses hearing aid hairpiece

Please record any injuries, surgeries, or accidents and when they occurred (month/year)

Float Intake Form

To ensure a comfortable, clean, and safe floatation experience, I agree to the following:

Please check each box.

- I am not under the influence of any medication, drug, or alcohol
- I do not have kidney disease
- I do not suffer from uncontrolled seizures or epilepsy
- I am not currently menstruating
- I have consulted with, and secured written permission from my physician to use the Floatation Cabin if I am pregnant
- I understand that using any self-tanning products or hair coloring must be complete at least 48 hours prior to floating.
- I agree to the mandatory 5-minute shower (full shampoo and body scrub) prior to floating, even if I have just showered prior to arrival. I agree to only use the soap and body wash provided prior to floating. Contamination of the spa water with outside products, bodily fluids, hair dye, etc. is my financial responsibility (up to a total of \$1000).
- I understand and will comply with the 24-hour rescheduling and cancellation policy. Up to 24 hours notice will be charged 50% of the service fee. No shows will incur the full service fee.

I further understand that each individual may have a unique experience. I have been given an orientation which familiarized me with the safe and appropriate use of the cabin. I agree to take full responsibility for my thoughts and actions while in the floatation cabin and the waiver of liability and all agreements made herein shall apply to each and every use of the floatation cabin.

I hereby agree to irrevocably release and waive any claims that I have now or may have hereafter against Revival Float Spa and its employees. I have read and fully understand and agree to the above terms of this Liability Waiver Agreement. I am signing this agreement voluntarily and recognize that my signature serves as complete and unconditional release of all liability to the greatest extent allowed by law in the State of Texas. I have read in its entirety and fully understand this Floatation Release Form.

Signature: _____ Date: _____