CELEBRATE
Health & Fitness

BEMER USER CHECK SHEET

Name: ______________________ Contact Number: ______________________

Address: ______________________

Email: ______________________

Date of Birth: ______________________ Occupation: ______________________

Employed ☐ Self Employed ☐ Full Time ☐ Part Time ☐

With **10 BEING EXCELLENT** and **1 BEING POOR,** how is your:

Sleep? ☐ Stress Level? ☐ Digestion? ☐ Energy? ☐ Mobility? ☐ General Wellbeing? ☐

1. Are you undergoing chemotherapy treatment? Yes ☐ No ☐
2. Are you taking steroids? Yes ☐ No ☐
3. Have you had an organ transplant? Yes ☐ No ☐
4. Are you taking immunosuppressant drugs? Yes ☐ No ☐
5. Are you taking medication at present? (If 'yes', please give details in comments below.) Yes ☐ No ☐
6. What body discomfort do you experience?
7. Are you experiencing pain at the moment? Yes ☐ No ☐

   If 'yes', please list where the pain is and rate the pain you are experiencing right now, from 1-10.
   '10' being the worst pain and '0' being no pain.

COMMENTS/MEDICATION:

BEMER products are in no way a substitute for medical care. There are no medical claims being made from the use of these products. Statements made have not been evaluated by the EU; however, BEMER products are EU registered Class 2 medical devices. They are not intended to diagnose, treat or cure any medical conditions or diseases. Please consult your own physician or health care provider if you have any medical concerns. By signing on the line below, you are stating that you are in agreement with all of the above.

It has been explained to me, the benefits of BEMER vascular therapy and I wish to take a session.

SIGNATURE: ______________________ **DATE:** ______________________