Questionairre for Floating Bath

|  |  |  |
| --- | --- | --- |
| 1 | ARE SUFFERING FROM ANY MENTAL ILLNESS FOR WHICH YOU MAY OR MAY NOT BE UNDER THE SUPERVISION OF A PSYCHIATRIST? (SENSORY DRPRIVATION MAY INCLUDE HALLUCINATION)  | YES /NO |
| 2 | ARE YOU SUFFERING FROM EPILEPSY? | YES/ NO |
| 3 | ARE YOU SUFERRING FROM HYPERTENSION?  | YES/ NO |
| 4 | ARE YOU SUFFERING FROM URINARY OR STOOL INCONTINENCE  | YES/ NO |
| 5 | ARE YOU TAKING ANY MEDICINE?IF YES,1. WHAT ARE THOSE MEDICATIONS?

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_1. HAVE YOU DISCUSSED WITH YOUR DOCTOR REGARDING SENSORY DEPRIVATION THERAPHY WHITH YOUR DOCTOR?

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  YES/NO |
| 6 | ARE YOU HAVING YOUR MENSTRUAL PERIOD AT THE MOMENT? ( FEMALES) | YES/NO |
| 7 | ARE YOU UNDER THE INFLUENCE OF ALCOHOL OR DRUGS AT HE PRESENT MOMENT?  | YES/NO |
| 8 | HAVE YOU CONSUMED COFFEIN OR ENERGY DRINK IN THE PAST 2-3 HOURS? | YES/NO |