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Consultation Form

CRYOSKIN

Basic Information

First Name: _____ Surname: _____ DOB: _____

Treatment History

1. Have you ever tried any other aesthetic procedures in the past?
   ☐Yes ☐No

2. If “yes”, which ones?

   _____

3. How did you hear about Cryoskin?

   ☐Friend/Family ☐TV/Radio ☐Internet ☐Other: _____

Background Information (please check all that apply)

☐Botox in the past 30 days
☐Surgery in the past 6 months
☐Pregnant and/or breastfeeding
☐Kidney and/or Liver disease
☐Lymphatic disorders
☐Severe allergy to cold
☐Eczema, rashes, or dermatitis
☐Circulatory disorders
☐Mesh inserts
☐HIV/AIDS
☐Using topical antibiotics
☐Cold-related Illness
☐Bacterial/viral skin infection
☐Impaired skin sensation
☐Hernia in desired treatment area
☐Fillers in the past 90 days
☐Implants in desired treatment area
☐Active/Past Cancer
☐Cardiovascular Disease
☐Uncontrolled Diabetes
☐Severe Raynaud’s Syndrome
☐Open or infected wounds
☐Pacemaker/metal implants
☐Incision scar(s) in the desired area
☐Body piercings in the desired area
☐Lower Limb Ischemia
☐Progressive diseases (MS, ALS, etc.)
☐Wound healing disorders
☐Known sensitivity to propylene glycol

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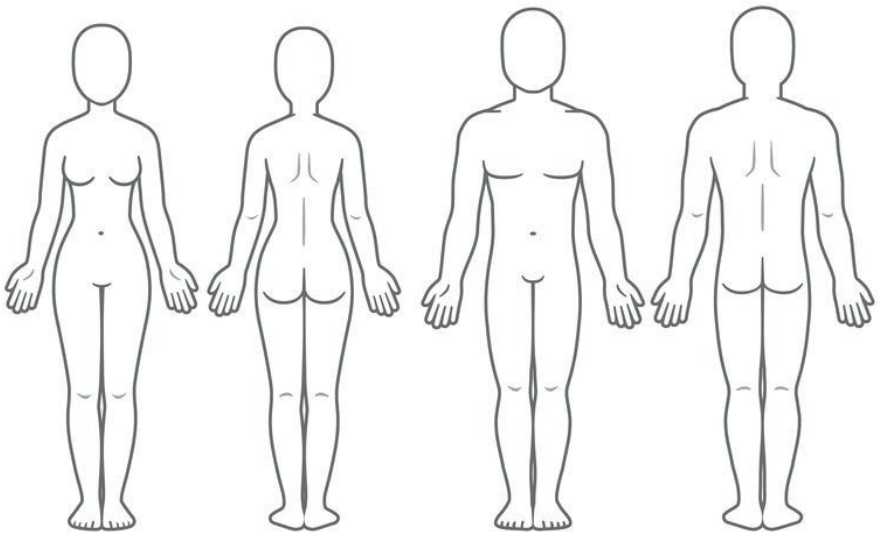
Lifestyle Information

1. How many times per week do you exercise? _____
2. How much water do you drink per day? _____
3. How would you rate your diet?
   ☐ Extremely healthy ☐ Generally healthy ☐ Needs improvement
4. Please circle your areas of concern:



5. Have any other treatments/diets/exercise regimens helped these areas?

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_____

6. What is your goal with Cryoskin?

_____

7. Do you have any questions about Cryoskin?

_____