CryoSkin Consultation Form

YOUR INFORMATION

Name: _____ Date of Birth: _____

Gender: _____ Address: _____

Email: _____ Phone Number: _____

Occupation: _____

Treatment History

Have you ever tried any other aesthetic procedures in the past?

Yes No

If “yes”, which ones?

_____

How did you hear about Cryoskin?

Friend/Family TV/Radio Internet Other: _____

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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

How many times per week do you exercise? _____

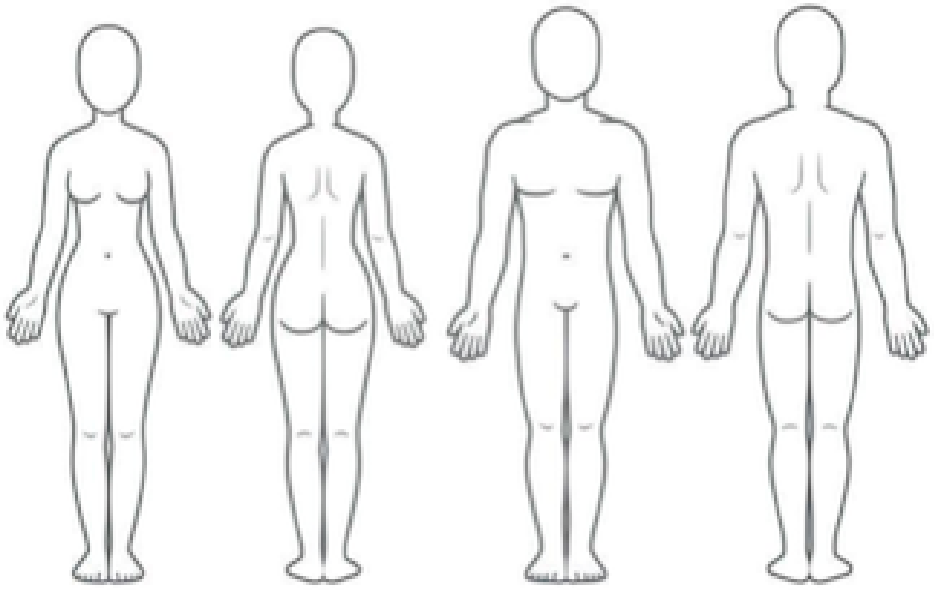
How much water do you drink per day? _____

How would you rate your diet?

Extremely healthy Generally healthy Needs improvement

Notes: _____

Please circle your areas of concern:



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

_____

_____

What is your current skin care regime/what products do you use?

_____

_____

List any dietary supplements you take:

_____

_____

What is your goal with Cryoskin?

_____

_____

Do you have any questions about Cryoskin?

_____

_____

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Client Notes for CryoSkin Technician:

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