CryoSkin | Signature Facials | Localized Cryotherapy | LED Light Facials | Pain Management

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 Aqua Spa Aesthetics at the Aqua Spa Float Center?

Friend/Family TV/Radio Internet Other: _____

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Background Information (please check all that apply)

- ❑ Botox in the past two weeks (microneedling)
- ❑ Botox in the past 30 days (cryoskin)
- ❑ Surgery in the past 6 months
- ❑ Keloid or raised scarring
- ❑ Kidney and/or Liver disease
- ❑ Lymphatic disorders
- ❑ Severe allergy to cold
- ❑ Eczema, rashes, or dermatitis
- ❑ Mesh inserts
- ❑ Using topical antibiotics
- ❑ Cold-related Illness
- ❑ Hernia in desired treatment area
- ❑ Actinic (solar) keratosis
- ❑ Herpes simplex infection
- ❑ Raised moles, wart or lesion in target area
- ❑ Fillers in the past 90 days
- ❑ Eczema, rashes, or dermatitis
- ❑ Circulatory disorders
- ❑ HIV/AIDS
- ❑ Bacterial/viral skin infection
- ❑ Blood clotting condition
- ❑ Impaired skin sensation
- ❑ Active/Past Cancer
- ❑ Cardiovascular Disease
- ❑ Uncontrolled Diabetes
- ❑ Immunosuppression
- ❑ Open or infected wounds
- ❑ Scleroderma, collagen or vascular disease
- ❑ Cardiac abnormalities
- ❑ Wound healing disorders
- ❑ Pregnant and/or breastfeeding
- ❑ Implants in desired treatment area
- ❑ Severe Raynaud's Syndrome
- ❑ Pacemaker/metal implants
- ❑ Incision scar(s) in the desired area
- ❑ Lower Limb Ischemia
- ❑ Body piercings in the desired area
- ❑ Progressive diseases (MS, ALS, etc.)
- ❑ Known sensitivity to propylene glycol or MDpen product
- ❑ Allergy to numbing agents

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Lifestyle Information

How many times per week do you exercise? ____

Are you seeing a personal trainer\fitness instructor? Yes

If Yes, how frequently? ____ No

How much water do you drink per day? ___

How would you rate your nutritional diet?

Extremely healthy Generally healthy Needs improvement

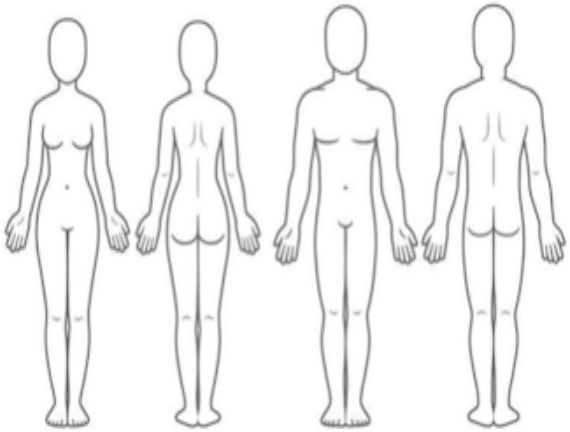
Please List any Dietary Supplements or Vitamins:

_____

Have any other treatments/nutritional plans/exercise regimens helped these areas? Yes No

_____

Please circle your areas of concern:



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Are you experiencing any pain in the areas of concern?
If so, please rate your pain level on the scale below.

Are you seeing a Specialist or Practitioner for your pain?

Yes ___ No ___ Type of Specialist/Practitioner_____

What is your goal for Cryoskin Pain Management and/or Localized Cryotherapy?

_____

Do you have any questions about Cryoskin Pain Management and/or Localized Cryotherapy?

_____

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Please read and sign your chosen consent below. If you have any questions please let your Esthetician know!

1. **Photo Consent:** Pictures will be obtained for records and documentation purposes.

Signature:_____ **Date:**_____

2. **Marketing & Educational Photo Consent:** Pictures will be obtained for records and documentation purposes. Pictures will also be used for education and marketing purposes. All identifying marks will be cropped or removed, unless the treatment is done on the face.

Signature:_____ **Date:**_____

3. **Food Allergy Waiver:** I attest to the best of my knowledge that I do not have any known food allergies.

Signature:_____ **Date:**_____

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Appointment Treatment Logs

Cryoskin Slim | Tone
Note:
Nutrition | Water | Exercise | Any relevant Medical information
Before & After Measurements | Client Goals | Email Status

Cryoskin Facial | Cryo T Facial
Note:
Goals | Improvements | Email status | Skin Care Regime | Products | Additional Services | Purchased Products |

Celluma
Note:

Goal | Skin Care Regime | Products used/purchased | Improvements
Organic Facials
Note:
Goal | Skin Care Regime | Products used\purchased

(Cryoskin) Pain Management
Note:
Area of Pain | Symptoms | Pain level pre & post treatment | Pain Management Plan Parameters

(Cryo T) Localized Cryotherapy
Note:
Area of Pain | Symptoms | Pain level pre & post treatment | Pain Management Plan Parameters

Date:	Service:	Notes:	Next Appt.Date

Date: **Service:** **Notes:** **Next Appt.Date**