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
□Impaired mental status
□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/implanted electrical devices
□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
□Current/recent bleeding or hemorrhage
□Regenerating nerves

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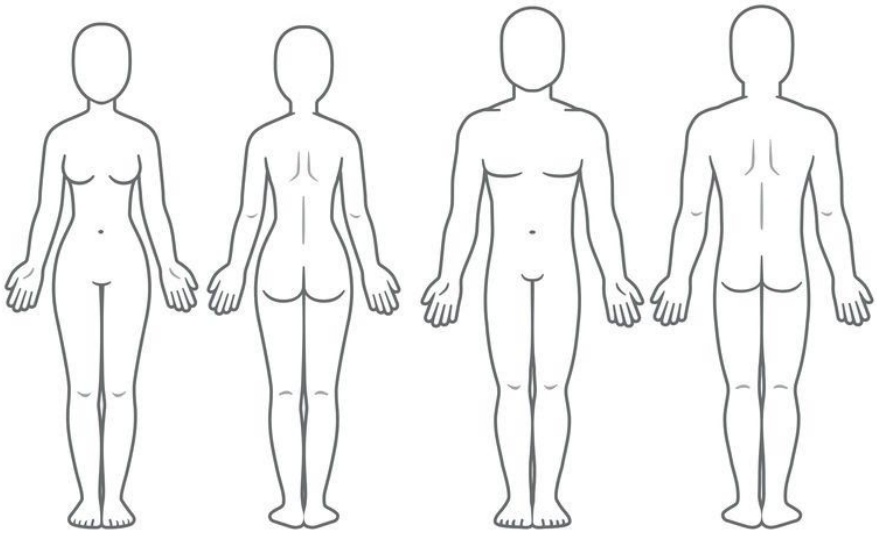
Lifestyle Information

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?