

CIRCADIAN CRYOSKIN CONSULTATION FORM

Basic Information

First Name: _____ Last Name: _____ 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)

- | | |
|-----------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Botox in the past 30 days | <input type="checkbox"/> Incision scar(s) in the desired area |
| <input type="checkbox"/> Fillers in the past 90 days | <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Body piercings in the desired area |
| <input type="checkbox"/> Surgery in the past 6 months | <input type="checkbox"/> Using topical antibiotics |
| <input type="checkbox"/> Implants in desired treatment area | <input type="checkbox"/> Lower Limb Ischemia |
| <input type="checkbox"/> Pregnant and/or breastfeeding | <input type="checkbox"/> Cold-related Illness |
| <input type="checkbox"/> Active/Past Cancer | <input type="checkbox"/> Progressive diseases (MS, ALS, etc.) |
| <input type="checkbox"/> Kidney and/or Liver disease | <input type="checkbox"/> Bacterial/viral skin infection |
| <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Wound healing disorders |
| <input type="checkbox"/> Lymphatic disorders | <input type="checkbox"/> Impaired skin sensation |
| <input type="checkbox"/> Uncontrolled Diabetes | <input type="checkbox"/> Known sensitivity to propylene glycol |
| <input type="checkbox"/> Severe allergy to cold | <input type="checkbox"/> Hernia in desired treatment area |
| <input type="checkbox"/> Severe Raynaud's Syndrome | <input type="checkbox"/> Current/recent bleeding or hemorrhage |
| <input type="checkbox"/> Eczema, rashes, or dermatitis | <input type="checkbox"/> Impaired mental status |
| <input type="checkbox"/> Open or infected wounds | <input type="checkbox"/> Regenerating nerves |
| <input type="checkbox"/> Circulatory disorders | |
| <input type="checkbox"/> Pacemaker/implanted electrical devices | |
| <input type="checkbox"/> Mesh inserts | |

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 list your areas of concern:

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

6. What is your goal with Cryoskin?

7. Do you have any questions about Cryoskin?

