Basic Information

Date: _________

Name: ____ DOB: __________

Email: ____

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 Raynaud's Syndrome

☐Open or infected wounds

☐Pacemaker/metal implants

☐Incision scar(s) in the desired area

☐Using topical antibiotics

☐HIV/AIDS

☐Fillers in the past 90 days

☐Breast implants

☐Active/Past Cancer

☐Severe Diabetes

☐Severe allergy to cold

☐Eczema, rashes, or dermatitis

☐Circulation disorders

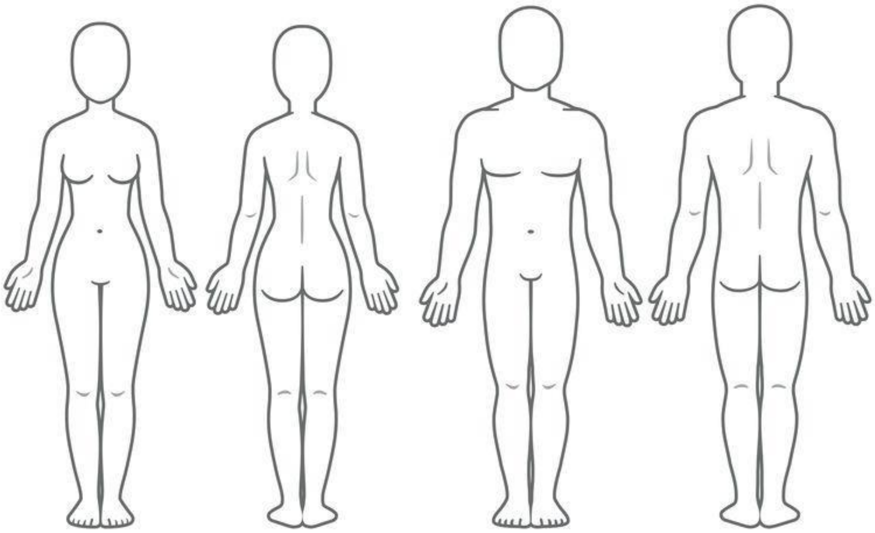
☐Mesh inserts

☐Body piercings in the desired area

☐Progressive diseases (MS, ALS, etc.)

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?

   ____

6. What is your goal with Cryoskin?

   ____

7. Do you have any questions about Cryoskin?