**Basic Information**

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_

**Treatment History**

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

◻Yes ◻No

1. If “yes”, which ones?

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1. How did you hear about us?

 ◻Friend/Family ◻TV/Radio ◻Internet ◻Other: \_\_\_\_\_\_\_\_\_\_\_\_

**Background Information** (please check all that apply)

◻Botox in the past 30 days ◻Fillers in the past 90 days

◻Surgery in the past 6 months ◻Breast implants

◻Pregnant and/or breastfeeding ◻Active/Past Cancer

◻Kidney and/or Liver disease ◻Uncontrolled Diabetes

◻Lymphatic disorders ◻Uncontrolled Diabetes

◻Severe allergy to cold ◻Severe Raynaud’s Syndrome ◻Eczema, rashes, or dermatitis ◻Open or infected wounds ◻Circulation disorders ◻Pacemaker/metal implants ◻Mesh inserts ◻Incision scar(s) in the desired area ◻HIV/AIDS ◻Body piercings in the desired area

◻Using topical antibiotics ◻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

1. Please circle your areas of concern:



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

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1. What is your goal with PDX CryoBody?

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1. Do you have any questions about treatment?

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