CRYO BREEZE
CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate laser treatment, we need you to complete the following questionnaire. All information is strictly confidential.

Name _____ Date of Birth _____

Address_____ City_____ State _____ Zip Code _____

Phone _____ Email _____

Emergency Contact Name and Phone _____

Which of the following best describes your skin type?

I. Always burns, never tans
II. Always burns, sometimes tans
III. Sometimes burns, always tans
IV. Rarely burns, always tans
V. Brown, moderately pigmented skin
VI. Black skin

MEDICAL HISTORY

Are you currently under the care of a physician? □ No □Yes If yes, for what: _____

Are you currently under the care of a dermatologist? □No □Yes If yes, for what: _____

Do you have a history of erythema ab igne, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation? □Yes □No

Do you have any of the following medical conditions? (Please check all that apply)

□Cancer	□Diabetes	□Hepatitis lesions	□High blood pressure	□Skin disease/Skin Lesions
□Herpes	□HIV/AIDS	□Thyroid imbalance	□Keloid scarring	□Frequent cold sores
□Arthritis	□Seizure disorder		□Hormone imbalance	□Any active infection

Other health problems or medical conditions? _____

Have you ever had an allergic reaction to any of the following? □Food □Latex □Aspirin □Lidocaine

□Hydrocortisone □Hydroquinone or skin bleaching agent □Others**:** _____

MEDICATIONS

What oral medications are you presently taking? □Birth control pills □Hormones □Others:_____

Are you on any mood altering or anti-depression medication? _____

Have you ever used Accutane? □No□Yes, last used it? _____

What topical medications or creams are you currently using? □ Retin-A® □Others:_____

What herbal supplements do you use regularly? _____

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HISTORY – In the area you would like to have treated:

Have you used any of the following hair removal methods in the past six weeks? □Shaving □Waxing □Electrolysis □Plucking □Tweezing □Stringing □Depilatories□Laser removal

Have you had any recent tanning or sun exposure that changed the color of your skin? □No □Yes

Have you recently used any self-tanning lotions or treatments? □No □Yes

Do you form thick or raised scars from cuts or burns? □No □Yes

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? □No □Yes If yes, please describe: _____

For our female clients:

Are you pregnant or trying to become pregnant? □Yes □No Are you breastfeeding? □Yes □No

CONSENT, RELEASE AND INDEMNITY AGREEMENT

The Cryo T-Shock safely and effectively uses thermal shock to naturally destroy fat cells without any damage to the skin. The Cryo T-Shock breaks down fat cells, which your body naturally flushes out through the bloodstream and the lymphatic system in days to weeks following the treatment. Cryo T-Shock also helps reduce the appearance of fine lines and wrinkles by stimulating collagen and elastin production while tightening muscles. The Cryo T-Shock is also beneficial for facial toning and lifting. Protocols will be discussed and or adjusted during consultation based on recommendations and client needs.

I understand that the results of Cryo T-Shock fat and/or cellulite reduction treatment (hereinafter referred to as "T-Shock Treatment") may vary depending on many individual factors, including but not limited to: medical history, prior treatments of the area being treated, skin type, compliance with pre- and post-care instructions and individual responses. I understand that for purposes of fat/cellulite reduction and/or skin toning I must maintain good dietary habits, maintain sufficient intake of water and participate in light physical activity as well as comply with all items, instructions and guidelines discussed during consultation prior to T-Shock Treatment.

I understand that any procedure involves risk. Known risks of T-Shock Treatment may include, but are not limited to: redness, swelling, irritation, skin reaction, or increased heart rate. Some individuals may experience delayed onset muscle soreness from treatments on the stomach due to unintentionally engaging the abdominals. Such muscle soreness ordinarily disappears later the same day. T-Shock Treatment may also entail risks not presently known or knowable.

Cryo T-Shock treatment should not be performed under the following conditions:

- Cryo T-Shock should not be applied over inflamed, infected, or swollen areas of the skin.
- Cryo T-Shock should not be applied over/near cancerous areas or on clients with active cancer or undergoing chemotherapy.
- Cryo T-Shock should not be used on clients who suffer from Kidney Disease.
- Cryo T-Shock should not be used on clients undergoing dialysis.
- Cryo T-Shock should not be used on clients who are pregnant.
- Cryo T-Shock should not be used on clients with varicose veins.
- Cryo T-Shock should not be used on clients who have had Botox treatments within 14 days or Filler treatments within 30 days.
- Cryo T-Shock should not be used on clients who suffer from severe diabetes where sensation has been lost in the skin.

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By signing this agreement, I acknowledge and represent that, to the best of my knowledge, I do not have any of the foregoing conditions. I further acknowledge that I have been honest and forthright about my medical history and am healthy to receive T-Shock Treatment. I am not pregnant, nor do I have any other disease or condition that may be negatively impacted by T Shock Treatment.

I have been informed and understand that, following T-Shock Treatment, a vigorous workout for at least thirty minutes is required on the same day in order to facilitate lymphatic drainage.

COVID-19 Warning. I understand that COVID-19 has been declared a worldwide pandemic by the World Health Organization. **The virus that causes COVID-19 is extremely contagious** and is believed to spread mainly from person-to-person contact. As a result, federal, state, and local governments and federal and state health agencies recommend social distancing and have, in many locations, prohibited the congregation of groups of people. I am aware that T-Shock Treatment may entail proximity to other individuals and human contact and therefore may increase my risk of becoming infected with the Coronavirus and of contracting COVID-19.

By signing this agreement, I voluntarily agree to assume all risks of undergoing T-Shock Treatment, whether included among the known risks listed above, or whether such risks are presently known, unknown or unknowable, including risks related to contracting COVID-19. I accept sole responsibility for any injury, illness, damage, loss, claim, liability, or expense of any kind that I incur in connection with T-Shock Treatment. I agree to unconditionally and forever release, covenant not to sue, discharge, and hold harmless Cryo Breeze employees, successors and assigns from any and all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating to T-Shock Treatment. I further agree that if any third-party brings legal or equitable claims that in any way relate to or arise from T-Shock Treatment performed on me against the Company and/or the Company's officers, directors, employees, agents, affiliates, representatives, successors and assigns (the "Indemnified Parties"), I will indemnify the Indemnified Parties for any liability or litigation costs incurred by Indemnified Parties as a result of such claims.

Acknowledgement: I understand each person has a different response to the T-Shock Treatment. The risks, benefits, and possible results have been explained to me. I have been provided the opportunity to ask questions and received satisfactory responses. I agree to have my photograph taken to document my results and will not be used for marketing unless agreed upon (see above). _____ Initial

By signing below, I acknowledge and certify that I, _____, have read and understand the "CONSENT, RELEASE AND INDEMNITY AGREEMENT" for this treatment, and that I am signing it voluntarily. Should any pain or discomfort occur I will immediately notify the staff. I understand that I must be at least 18 yrs old to participate in this treatment. I UNDERSTAND THAT ALL SALES ARE FINAL AND REFUNDS ARE NOT PERMITTED.

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Print Name _____ Date _____

Signature _____