

Cryolipolysis Customer Form

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Client Name:** | | | **Address:** | | |
| **Date of Birth:** | | | **Post Code:** | | |
| **Gender:** Male Female | | | **Telephone No:** | | |
| **Occupation:** | | | **E-Mail:** | | |
| **Practitioner Name:** | | | **Date:** | | |
| **Health and Lifestyle** | | | | | |
| **Contraindications** |  |  | **Do you have any of the following?** |  |  |
| Liver/Kidney Disease | YES | NO | Hyper or Hypotension | YES | NO |
| Heart Conditions inc. Pacemaker | YES | NO | Scarring history, fibrosis or seborrhoea | YES | NO |
| Silicosis or other Lung Conditions | YES | NO | Haemophilia or other clotting disorders | YES | NO |
| Cancer (Radiotherapy/Chemotherapy) | YES | NO | Epilepsy | YES | NO |
| Reynaud’s Disease (or other vaso constrictive disorders) | YES | NO | Diabetes | YES | NO |
| Physical Hypotonic | YES | NO | Thyroid Condition | YES | NO |
| Cardiovascular Disease | YES | NO | Hormonal Imbalances | YES | NO |
| Cerebral Disease | YES | NO | Other immune disorders not listed | YES | NO |
| Immune System Disease (i.e. AIDS or HIV) | YES | NO | Received or donated organ transplants | YES | NO |
| Urticarial or other immune disorders | YES | NO | Psoriasis or eczema in treatment area | YES | NO |
| Hypoproteinaemia | YES | NO | Keloid/hypertrophic scar in the region | YES | NO |
| Frostbite Intolerance | YES | NO | High Cholesterol | YES | NO |
| Hernia or weak stomach muscle walls | YES | NO | Thrombosis (past or present) | YES | NO |
| Severe diabetes | YES | NO | Broken Bones | YES | NO |
| Recent invasive surgery (in the last 12 months) | YES | NO | Undiagnosed swelling or inflammation | YES | NO |
| Artificial Implants (bone, etc) | YES | NO | Bruising, cuts or abrasions (treatment area) | YES | NO |
| Metal Plates or Joint Implants | YES | NO | Fever | YES | NO |
| Sites of prior cosmetic surgery | YES | NO | Menstruation | YES | NO |
| Any other conditions not listed | YES | NO |
| **If yes please list:** | | |
| Pregnant or Breastfeeding | YES | NO |
| Currently under the influence of drugs or alcohol | YES | NO |
| If you have answered yes to any of the above, please give full details: | | | | | |
| Are you currently taking any medication? | | | | YES | NO |
| If yes, please list all medications | | | | | |
| How is your sleep pattern? Good Average Poor | | | No. of Hours Sleep per night: |  | |
| How is your diet? Good Average Poor | | | How much water do you drink per day? |  | |
| Do you drink alcohol? | YES | NO | If yes, how many units per week? |  | |
| Do you smoke? | YES | NO | If yes, how many cigarettes per day? |  | |
| Do you exercise? | YES | NO | How often do you exercise per week? |  | |
| Have you ever had cryo body contouring or any fat removal or similar treatments before? If yes, please give details below including the type of treatment and the area. | | | | YES | NO |
| Are you fully committed to making the relevant changes to get the best possible results  from your treatment? | | | | YES | NO |