Whole Body Cryotherapy
Consent Form

PATIENT DETAILS:

Name:_____ Date of Birth: _____ Contact Number: _____

Address:

E-mail Address: _____

Are you taking any medication? (Y/N) _____

If yes, please state: _____

Emergency Contact Details: Name: _____ Relationship: _____ Contact number: _____

Please read the information below CAREFULLY. If you suffer from any of the contraindications listed below it is advised that you DO NOT PARTICIPATE IN ANY Cryostimulation treatments. From the list of absolute contraindications to Cryostimulation below, tick the boxes that currently apply to you:

	Yes	No		Yes	No
➢ cold intolerance	☐	☐	➢ hypothyroidism	☐	☐
➢ cryoglobulinaemia	☐	☐	➢ pregnancy after the 4th month	☐	☐
➢ cryofibrinogenemia	☐	☐	➢ local blood flow disturbances	☐	☐
➢ cold utricaria	☐	☐	➢ acute respiratory or lung diseases of various origin	☐	☐
➢ open wounds and ulcers	☐	☐	➢ cancer	☐	☐
➢ gangrenous lesions	☐	☐	➢ severe anaemia	☐	☐
➢ thromboembolic changes and inflammation in venous system	☐	☐	➢ under the influence of drugs, especially antipsychotics and alcohol	☐	☐
			➢ Metal pins or plates	☐	☐

I confirm that to the best of my knowledge, the answers I have given are correct and I have not withheld any information that may be relevant to my treatment. I certify that the proceeding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform my therapist of my current medical or health conditions and to update this history, as a current medical history, is essential to execute appropriate treatment procedures.

Due to Cryostimulation being contraindicated under certain conditions, I confirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and I understand there shall be no liability on the therapist's part should I forget to do so.

I understand I may be asked to remove clothes as part of the treatment (not underwear). I am signing this consent form to ensure my dignity is held in high regard at all times by the professional. I understand I will be offered towels and robes at the start of the treatment (if required).

I am happy to proceed with the process that I am entering into and I do so at my own risk. By signing the consent form I agree that I have read and understood the contraindications to Cryostimulation treatments. The risks of the treatment have been explained to me and I have had an opportunity to discuss and clarify any concerns with the trained personnel. The signature below confirms my consent to undergo Cryostimulation treatment.

DATE & SIGNED

Dated: _____ Cryotherapy technician Name: _____

Client Signature: _____ Cytotechnician Signature: _____