Whole Body Cryotherapy Intake Form

Please fill in, read carefully and sign before the first procedure

Full Name:_____ Date: _____

Email:_____ Phone: _____

Date of Birth:_____ Address:_____

City:_____ State & Zip:_____

How did you hear about us? _____

What is your reason for visiting us today? _____

Contraindications Acknowledgment

NOTE: Conditions marked with ** are contraindications and participation is prohibited.

Are you currently prescription medication? If yes, please list: _____
_____

**Do you have any environment-related allergies (i.e. cold allergies or snow allergies)? If yes, please specify: _____

Are you currently under medical care for any reason? If yes, please briefly explain: _____
_____

**Do you have a pacemaker? _____ **Are you pregnant? _____

Severe Cardiovascular Conditions

Do you have any of the following conditions? (Please indicate “Yes” or “No”).

**Untreated Hypertension (BP> 160/100):	Yes__ No__
High blood pressure:	Yes__ No__
Low blood pressure:	Yes__ No__
**Unstable Angina Pectoris:	Yes__ No__
**Peripheral Arterial Occlusive Disease:	Yes__ No__
**Ischemic Heart Disease:	Yes__ No__
**Edema of the cardiovascular and/or respiratory system:	Yes__ No__

Asthma/ Shortness of breath: Yes__ No__
**Epilepsy: Yes__ No__
**Congestive Heart Failure, COPD, or Chronic Liver Disease: Yes__ No__

Circulatory/Skin Conditions
Do you have any of the following conditions? (Please indicate “Yes” or “No”).

**Deep Vein Thrombosis (DVT) or a known circulatory dysfunction: Yes__ No__
Vasculitis: Yes__ No__
**Bacterial or viral infections of the skin, wound
healing disorders, open sores: Yes__ No__
Raynaud’s Disease: Yes__ No__

Blood Disorders
Do you have any of the following conditions? (Please indicate “Yes” or “No”).

**Severe Anemia: Yes__ No__
**Heavy consumerist diseases (abnormal bleeding): Yes__ No__

Conditions of the Nervous System/Kidney & Liver Function
Do you have any of the following conditions? (Please indicate “Yes” or “No”).

Diabetes: Yes__ No__
Acute kidney or urinary tract diseases: Yes__ No__
**Seizure disorders: Yes__ No__
Hyperhidrosis/heavy perspiration: Yes__ No__
**Polyneuropathies: Yes__ No__

Other General Health Concerns
Do you have any of the following conditions? (Please indicate “Yes” or “No”).

**Acute Febrile Respiratory (Flu-like respiratory conditions): Yes__ No__
Claustrophobia: Yes__ No__
Alcohol or drug-related contraindications: Yes__ No__

Medical History
Have you have any of the following conditions? (Please indicate “Yes” or “No”).

Heart Attack: Yes__ No__
**Heart Attack within the previous 6 months: Yes__ No__
Stroke: Yes__ No__
Sudden loss of consciousness: Yes__ No__
Surgeries within the last year: Yes__ No__
Serious injury: Yes__ No__

Safety Instructions for Whole Body Cryotherapy

You must wear cotton or wool socks and gloves (both provided by Charm City Integrative Health) as well as your own underwear in order to avoid chilblain.

Treatments are limited to 3 minutes per session to avoid overexposure and frostbite.

During the treatment, you must keep your head over the top of the cryo-chamber to avoid inhaling the nitrogen vapor; while non-toxic, it is devoid of oxygen and may cause fainting.

You may request stopping the procedure at any time if you experience problems or anxiety.

Abnormal skin sensitivity to cold may be caused by certain foods, cosmetics, or medication, including but not limited to tranquilizers and blood pressure medication.

A person who is less than eighteen (18) years of age may not use the Whole Body Cryotherapy without parental consent.

Risks of Cryotherapy

- Fluctuations in blood pressure due to peripheral vasoconstriction, blood pressure may briefly increase by up to 10 points systolically during treatment. This effect should reverse after the end of the procedure, as peripheral circulation returns to normal.
- Allergic reaction to extreme cold (rare).
- Claustrophobia and/or anxiety.
- Activation of some viral conditions (i.e. cold sores) due to stimulation of the immune system.

In consideration for being permitted by Charm City Integrative Health to participate in their Cryotherapy activity, I hereby waive any and all claims and damages for personal injury or death which may occur as a result of my participation. I understand and agree that:

1. This release is intended to discharge in advance Charm City Integrative Health, its officers, employees, and agents from and against all liability arising out of or connected in any way with my participation in cryotherapy.
2. I hereby confirm that no warranty or guarantee, or other assurance, has been made to me covering the results of the cryotherapy process, and I hereby release, indemnify and hold harmless Kryolife, its officers, employees and agents, from all liabilities for injury or damage that may occur to me. I fully understand the administration of the process, including possible adverse reactions, side effects, or other possible complications. It is understood that this CONSENT is being given in advance of any administration of the process, and is being given by me voluntarily to use the equipment.
3. Participation may involve risk of serious injury, illness, disability or death and may occur not only as a result of my actions, negligence or inaction but also from the action, negligence or inaction of others, including their owners, officers, employees or agents, may result from the conditions of the facilities or areas where such activities are being conducted.

4. Knowing the risks involved and the contraindications related, I nevertheless chose voluntarily to request permission to participate.
5. I will indemnify and hold harmless Charm City Integrative Health, its owners, employees, and agents from any loss, liability, damage. Cost or expense, including litigation of any form, arising out of or connected in any manner with my participation in such activities.
6. I am in good health and have no physical condition expressed as a ‘Contraindication’ (** in front of it) or otherwise which would preclude me from safely participating in such activities; I have been advised that if I suffer from any medical condition or illness whatsoever, I am NOT TO USE the equipment without my doctor’s written permission.
7. I understand and agree that this release is intended to be as broad and inclusive as permitted under Maryland law and that if any portion of the Liability, Medical Release and Indemnification Agreement should be determined to be invalid, it is my intent that the remaining provisions shall continue in full force and effect.

BY SIGNING THIS RELEASE, I ACKNOWLEDGE AND REPRESENT THAT I have read and understood the foregoing and that the proposed cryotherapy process has been satisfactorily explained to me and I have all the information I desire. I am at least eighteen (18) years of age and fully competent; and I execute this document for full, adequate, and complete considerstion, fully intending to be bound by the same. Furthermore, I agree that I will comply with all instructions on the use of the cryotherapy device and that I am using these services at my own risk.

I AM AWARE THAT THIS IS A RELEASE OF LIABILITY AND A POTENTIAL CONFLICT BETWEEN MYSELF, AND MY HEIRS AND CHARM CITY INTEGRATIVE HEALTH. I VOLUNTARILY AGREE TO EACH OF THE TERMS AND PROVISIONS HEREIN AND SIGN THIS OF MY OWN FREE WILL.

_____

Name (Print) Date

_____

Signature

_____

Parent of Guardian (Print) Sign Date

Disclaimer: Statements within this site are for informational purposes only. Our products are not medical devices. They are not intended to diagnose, treat, cure, or prevent any disease, and have not been tested or approved by the FDA or any other US government agency for the treatment of any illness or disease.

Thank you and enjoy the treatment!