Cryotherapy Intake
&
Informed Consent

Today's Date (mm/dd/yyyy): _____ Date of Birth (mm/dd/yyyy): _____

First Name: _____ Last Name: _____

Address: _____ City: _____

Zip: _____ State: _____

Phone: _____ Email: _____

How did you hear about us? _____

Contraindications acknowledgment:
Are you currently taking any medications? (Including any vitamins or supplements)
If so, please list:

_____

_____

Questions: Yes / No
Severe Cardiovascular Conditions

- Do you have untreated Hypertension? Yes __ No __
- Do you have Peripheral Arterial Occlusive Disease? Yes __ No __
- Have you had a heart attack within the previous 6 months? Yes __ No __
- Do you have Valvular heart disease? Yes __ No __
- Do you have Unstable Angina Pectoris? Yes __ No __
- Do you have Ischemic heart disease? Yes __ No __
- Do you have any heart surgery conditions? Yes __ No __
- Do you have a pacemaker? Yes __ No __
- Do you have decompensating diseases (edema) of the cardiovascular and
- respiratory system, congestive heart failure, COPD, or chronic liver disease?
  Yes __ No __

Circulatory/Skin Conditions

- Do you have Deep Vein Thrombosis (DVT) or a known circulatory
- dysfunction? Yes __ No __
- Do you have Raynaud's disease? Yes __ No __
- Do you have bacterial or viral infections of the skin, wound healing disorders
- (open sores or discharging wound/skin conditions)? Yes __ No __
- Do you have Vasculitis? Yes __ No __

Blood Disorders

- Do you have severe anemia? Yes __ No __
- Do you have heavy consumerist diseases (abnormal bleeding)? Yes __ No __

Conditions of the Nervous System / Kidney & Liver function

- Do you have diabetes? Yes __ No __
- Do you have acute kidney or urinary tract diseases? Yes __ No __
- Do you have any seizure disorders? Yes __ No __
- Do you have Hyperhidrosis - heavy perspiration? Yes __ No __
- Do you have Polyneuropathies? Yes __ No __

Other General Health Conditions

- Do you have acute febrile respiratory (Flu like respiratory conditions)? Yes __ No __
- Are you claustrophobic? Yes __ No __
- Do you have Cold Allergenic Phenomenon
- (known allergy to cold contactants)? Yes __ No __
- Do you have any alcohol or drugs related contraindications? Yes __ No __
- Are you Pregnant? Yes __ No __

If yes, check all that apply:
__Lower back pain
__Spinal disc problems
__Major joint dislocation
__Cartilage or tendon tear
__Arthritis or Bursitis
__Ligament strain
__Overuse condition of the knee, shoulder, hip, elbow or other joint

Have you had any cosmetic treatments (including botox or similar injectables, cellulite reduction, weight loss procedures, implants) Yes __ No __

If yes, type of treatment:

Fact Sheet - Whole Body Cryotherapy (WBC)

The word ”Cryotherapy” stems from the Greek words: “cryo” or cold, and ”therapeia” or cure. Hence, whole body cryotherapy (WBC) is being studied as a curative and overall beneficial treatment involving skin exposure to extremely low temperatures (below -130°C/ below -266°F). Since the cooling process affects no more than 5% of the body (i.e. the parts that safely endure the variations of temperature), the treatment generally is comfortably endured.

These temperatures have potential medicinal and aesthetic benefits.

Endocrine System:
The extreme cold exposure is believed to cause the body to turn up its metabolic rate in order to produce heat. This effect lasts for 5-8 hours after the procedure, causing the body to ‘burn’ 500 – 800 calories. After several procedures, the increase in metabolic rate tends to last longer between treatments. Another ‘survival reaction’ to the extreme temperatures is the release of endorphins (hormones) that have analgesic and anti-inflammatory properties, and improve mood disorders. WBC has been studied for the successful treatment of medication resistant depressive disorders.

Skin:
The outer skin is briefly frozen, which is believed to increase production of collagen in deeper layers of the skin, keeping skin looking young and vibrant. Skin vessels and capillaries undergo severe vasoconstriction (to prevent core temperature from dropping), followed by vasodilation after the procedure. Toxins and other stored deposits are flushed out of deeper layers of the skin and blood perfusion is improved after several treatments. The anti-inflammatory properties of WBC may ameliorate chronic skin conditions such as psoriasis and dermatitis.

Musculoskeletal System:
The anti-inflammatory and analgesic properties of WBC can improve symptoms of ankylosing spondylitis, as rheumatoid- and osteoarthritis. Athletes utilize WBC to speed recovery injury or exercise-induced muscle damage and to optimize key components of performance.

WAIVER OF LIABILITY AND MEDICAL RELEASE AND INDEMNIFICATION AGREEMENT

PLEASE READ CAREFULLY BEFORE SIGNING

This is a release of liability and a waiver of certain legal rights. Participation in a Cryotherapy session involves exposure to extreme cold temperature for a short period of time (not to exceed three (3) minutes per session).

Below is a list of absolute 'Contraindications' which will preclude you from participation. In addition, PLEASE BE AWARE, that if you experience any pain or mental or physical discomfort at any time during the process, you are advised to terminate the session immediately upon your own volition. You will be observed by a technician the entire time while in the chamber, but should advise the technician IMMEDIATELY if you feel any discomfort.

ABSOLUTE CONTRAINDICATIONS:
(Participation in cold therapy session not allowed)

- Untreated Hypertension
- Heart attack within previous 6 months
- Decompensating diseases (edema) of the cardiovascular and respiratory system; congestive heart failure, COPD, chronic liver disease
- Unstable Angina Pectoris
- Pacemaker
- Peripheral Arterial Occlusive Disease
- Deep Vein Thrombosis (DVT) or known circulatory dysfunction
- Acute febrile respiratory (Flu like respiratory conditions)
- Acute kidney and urinary tract diseases
- Severe Anemia
- Cold Allergenic Phenomenon (known allergy to cold contactants)
- Heavy consumerist diseases (abnormal bleeding)
- Seizure disorders
- Bacterial and viral infections of the skin, wound healing disorders (open sores or discharging wound/skin conditions)
- Alcohol and drug related contraindications
- Valvular heart disease
- Conditions after heart surgery
- Ischemic heart disease
- Raynaud's disease
- Polyneuropathies
- Pregnancy
- Vasculitis
- Claustrophobia
- Hyperhidrosis - heavy perspiration
- Diabetes

This list may not be all inclusive, so if you have any particular health problem which you believe would preclude you from participating in exposure to extreme cold, please check with your treating physician before participating.

Safety Instructions – What to Wear

Because of the exposure to extremely cold temperatures, there are mandatory requirements for apparel to be worn in the chamber. You should arrive in or bring the following gym attire: Men recommended: (swimsuit or shorts, T-shirt, cotton or wool socks). Women recommended: (swimsuit or shorts and top, cotton or wool socks). Please avoid wearing jeans, slacks, or other loose fitting clothing as they have a tendency to harden immediately, making walking more difficult. All jewelry and piercing(s) must be removed before entering the cryo sauna.

This short duration of exposure would be safe even without the protective apparel. However, KryoLife insists that you wear the mandatory cover for your skin and respiratory protection and to maximize the benefits of your experience.
You should not exercise or shower prior to the chamber treatment. Any type of body condensation will freeze during exposure. It is recommended that you pat yourself dry with a towel before entering the chamber and do not apply lotions, oils, cologne or any alcohol based products prior to treatment.

Behavior during the Treatment

1. Treatments are limited to 3 minutes per session. Overexposure to the cold temperatures may cause chilblain;
2. During the treatment, you must avoid inhaling the nitrogen fumes. While non-toxic, the fumes are devoid of oxygen and may cause fainting. Avoiding the fumes can be simply accomplished by keeping your head above the chamber.
3. During treatment, you must keep your hands visible to the operator at the upper rim of the chamber as instructed;
4. You may end the procedure at any time if you experience any problems or anxiety. If you experience any problems, you should notify the operator immediately.
5. Abnormal skin sensitivity to cold may be caused by certain foods, cosmetics, or medication, including but not limited to the following:

   Tranquilizers, blood pressure medication;

6. A person who is less than (18) years of age may not use 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, anxiety, activation of some viral conditions (cold sores) etc. 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 these activities;

2. I hereby confirm that no warranty or guarantee, or other assurance, has been made to me covering the results of the cryo 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 result 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 in the 'Contraindications' 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 this 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.

IN SIGNING THIS RELEASE, I ACKNOWLEDGE AND REPRESENT THAT I have read and understand the foregoing and the proposed cryotherapy process has been satisfactorily explained to me and I have all of 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 consideration fully intending to be bound by same. Furthermore, I agree that I will comply with all instructions on the use of the cryo 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 or Guardian (Print) (Sign) Date

Thank you & Enjoy the treatment