Cryofacial Intake Form

General Information

Name
Date of Birth
Address
City
State
Zip Code
Phone #
Email
Occupation
Emergency Contact Name
Phone #
Would you like to be added to our email list for specials and discounts? Yes ☐ No ☐
How did you hear about us?

Medical History

Please check all that apply:

☐ ALS	☐ Metal implants	☐ Severe Allergy to Cold
☐ Bacterial Infection	☐ MS	☐ Severe Raynaud's
☐ Circulatory Disorder	☐ Neuropathy	☐ Viral Infection
☐ Dermatitis	☐ Parkinson's	☐ Wound Healing Disorder
☐ Eczema	☐ Rashes	☐ Other: ____________

Are you currently taking any medications? Yes ☐ No ☐
If yes, please list:
Have you had any facial or dermatology services in the past 90 days? Yes ☐ No ☐
If yes, please explain:
Do you have any allergies? Yes ☐ No ☐
If yes, please explain:
Have you had any surgeries in the past year? Yes ☐ No ☐
If yes, please explain:

Have you had aesthetic fillers, injectables or laser treatments in the last 6 months? Yes ☐ No ☐
Do you have any irremovable body piercings in the desired treatment area? Yes ☐ No ☐
Do you have any implants in the desired treatment area? Yes ☐ No ☐

By signing below, I agree to the following:
I have completed this form to the best of my ability and knowledge. I agree to inform the technician of any changes in the above information. I agree that I do not have any condition(s) that would make the requested treatment unsuitable. I agree to waive all liability toward my technician and the salon for any injury or damages incurred due to any misrepresentation of my health.

____________	____________	____________
Name Printed	Signature	Date

Cryofacial Informed Consent Form

Please read and initial each of the statements below:

________ I have voluntarily elected to receive a Cryofacial after the nature and purpose of this treatment has been explained to me.

________ I understand that this treatment can be used to accelerate collagen production, diminish the appearance of fine lines and wrinkles, improve texture/tone, reduce pore size, and give skin a smoother more plump appearance.

________ I understand that this service will expose me to extremely cold temperatures.

________ I recognize there are no guaranteed results and that independent results are dependent upon age, skin condition, and lifestyle, and that there is a possibility I may require further treatments of the treated areas to obtain the expected results at an additional cost.

________ I understand that I may experience numbness or tingling of the face, temporary skin discoloration, or ice burn, but these side effects are normal and generally subside within a few hours.

________ I understand that although complications are very rare, sometimes they may occur and that prompt treatment is necessary. In the event of any complication, I will immediately contact the skin care professional who performed the treatment or seek medical attention.

________ I have disclosed any surgical procedures, implants, laser treatments, or facial procedures that I have had or intend on having in the future.

________ I have not recently exfoliated the area being treated today.

________ I have, to the best of my knowledge, given an accurate account of my medical history, including all known allergies or prescription drugs or products I am currently ingesting or using topically.

________ I understand that the following conditions preclude me from having this treatment at this time and verify that none of these conditions apply to me at this time.

- ALS
- Bacterial Infection
- Circulatory Disorder
- Dermatitis
- Eczema
- Metal implants
- MS
- Neuropathy
- Parkinson's
- Rashes
- Severe Allergy to Cold
- Severe Raynaud's
- Viral Infection
- Wound Healing Disorder

________ I consent to the taking of photographs to monitor treatment effects and results if desired by my skincare professional.

I have read and fully understand this agreement and all information detailed above. The information provided has been explained to me and all my questions have been answered to my satisfaction. I understand the procedure, accept the risks, and consent to have the treatment done. I agree I will assume the risk and full responsibility for any and all injuries, losses, side effects, or damages that might occur to me while I am undergoing this procedure. I do not hold the esthetician, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this skincare procedure, which may be affected by the treatment performed today.

____________________	____________________	____________________
Printed Name	Signature	Date
____________________	____________________	____________________
Esthetician Name	Signature	Date