LIPOFREEZE 2U

# 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** | | |
|---|---|---|---|---|---|
| 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 constrict 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 |
| | | | Do you have a pacemaker or any other electronic device fitted within your body? | YES | NO |
| | | | Do you have a copper coil fitted? | 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 |