Thrive CryoStudio Cryoskin 2.0: Information Form

First Name: ______________________ Last Name: _______________________

Background Information

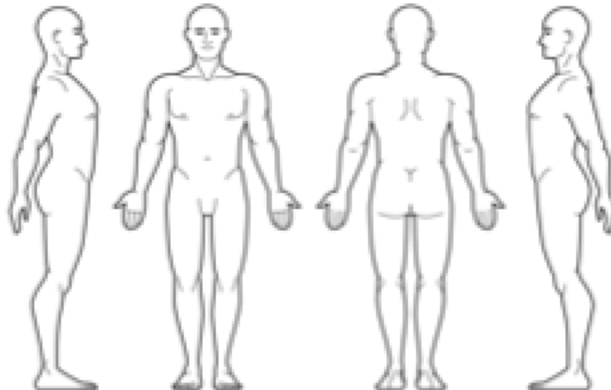
1. Have you had any other aesthetic procedure(s) before? yes no
2. If "yes", what? ____
3. How did you hear about Cryoskin 2.0? TV Friend Internet Podcast Other:___________
4. How did you hear about Thrive CryoStudio? _________________________

Cryoskin 2.0 Information

1. Do you have any of the following? (*Check all that apply*)

Botox/Fillers (last 3 months)	Surgery (last 3 months)	Breast Implants
Pregnant	Lactation	Cancer (present or past)
Cold Sensitivity/Reynaud's	In Vitro Fertilization (IVF)	Open or Infected Wounds
Scar Tissue (in the area to be treated)	Eczema, Rashes or Dermatitis	Circulation Disorder(s)
□ Liver and/or Kidney Disease	□ Diabetes	□ Foreign Ointments on Skin

2. Please circle area of focus for today's Cryoskin 2.0 treatment:



3. What other treatments/medications/exercises or diets have you tried (*for the items you checked above*)?

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4. Did any of the other treatments/medications/exercises work? Yes No
5. What is your goal with Cryoskin 2.0? ____
5. Do you have any specific questions about Cryoskin 2.0?

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Pictures will be obtained for records. If pictures are used for education and marketing purposes, all identifying marks will be cropped or removed, unless the Cryoskin 2.0 treatment is done on the face.

Initial: ___________

This completed form is for informational purposes only. Thrive CryoStudio and its staff are not medical professionals, and do not claim to be. We are Cryoskin 2.0 experts and hold the highest standard of safety, customer service and education. The Cryoskin 2.0 products and equipment have not been tested or approved by the FDA or any other government agencies for the treatment of any illness or disease. Use at your own risk.