ANDY SWAN
Sports & Remedial massage therapist

LOCAL CRYSTIMULATION
CONSENT FORM

This is a consent form for local Cryostimulation treatments. Please read the information below carefully. If you suffer from any of the contraindications listed below it is a advised that you do not participate in any Cryostimulation treatments or have the affected area exposed to extreme cold temperatures. Any specific concerns should be discussed with a specialist or trained personnel prior to signing the consent form.

PATIENT DETAILS

Full Name		
Date Of Birth		
Address		
Contact Number		
Email Address		
Emergency Contact Details	Name	
	Relationship	
	Contact Number	
Are you currently on any medication	yes ☐ No ☐	

If yes , Please state	

From the list of absolute contraindications to Cryostimulation below, tick the appropriate boxes that apply to you:

	Yes	No
• Cold intolerance – Cryoglobulinaernia, Cryofibrinogenemia, cold utricaria	☐	☐
• Throboembolic changes and inflammation in the venous system	☐	☐
• Agammaglobulinemia	☐	☐
• Hyperthyroidism	☐	☐
• Cancer	☐	☐
• Acute respiratory or lung diseases of various origin	☐	☐
• Severe anemia	☐	☐
• Pregnancy after the 4th month	☐	☐
• Thos under the influence of drugs, especially antipsychotics and alcohol	☐	☐

Below is a list of contraindications for localised regions of the body. If ‘yes’ is ticked in any of the boxes below. Local Cryostimulation below, tick the appropriate boxes that currently apply to you:

	Yes	No
• Open wounds and ulcers.	☐	☐
• Gangrenous lesions	☐	☐
• Hypothyroidism (avoid throat)	☐	☐
• Cold intolerance	☐	☐

Please tick the box to agree to the terms and conditions below:

☐ I confirm that to the best of my knowledge, the answers I have given are correct and I have not withheld any information that may be relevant to my treatment. I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform my therapist of my current medical or health conditions and to update this history as a current medical history is essential for her / him to execute appropriate treatment procedures. Due to Cryostimulation being contraindicated under certain conditions. I confirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapists part

☐ I fully understand the administration of the process, including possible adverse reactions, side effects or the other possible complications. It is understood that this Agreement is being given in advance of any treatment. I understand that Cryostimulation is provided for the purpose of relaxation, stress reduction, relief and recovery of muscular tension, recovery from surgery, help several skin conditions and aid in cellulite reduction and detoxification. I further understand that Cryostimulation should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a GP, Chiropractor or another qualified medical specialist for any mental or physical ailment that I am aware of.

By signing the consent form I agree that I have read and understood the contraindications to Cryostimulation treatments. The risks of the treatment have been explained to me and I have had an opportunity to discuss and clarify any concerns with the specialist or trained personnel. The signature below confirms my consent to undergo Cryostimulation treatment/s

_____ _____ _____

Patient Signature Parent/Guardian Signature Date