



Medical History Form

Date: _____ Date of Birth: _____

First Name: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Email: _____

Client Blood Pressure _____

How did you hear about CYCLE & CRYO Body Mind?

__ Search engine _____ Referral-If yes, Name _____

__ News Article or publication _____ Advertisement- If yes, Which _____

__ Medical Professional- If yes, Name _____

Contraindications acknowledgment:

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

Questions: Yes / No

Severe Cardiovascular Conditions

- | | | |
|---|---------|--------|
| <input type="checkbox"/> Do you have untreated Hypertension? | Yes ___ | No ___ |
| <input type="checkbox"/> Do you have Peripheral Arterial Occlusive Disease? | Yes ___ | No ___ |
| <input type="checkbox"/> Have you had a heart attack within the previous 6 months? | Yes ___ | No ___ |
| <input type="checkbox"/> Do you have Valvular heart disease? | Yes ___ | No ___ |
| <input type="checkbox"/> Do you have Unstable Angina Pectoris? | Yes ___ | No ___ |
| <input type="checkbox"/> Do you have Ischemic heart disease? | Yes ___ | No ___ |
| <input type="checkbox"/> Do you have any heart surgery conditions? | Yes ___ | No ___ |
| <input type="checkbox"/> Do you have a pacemaker? | Yes ___ | No ___ |
| <input type="checkbox"/> 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 ___
- Are you currently receiving Physical Therapy Yes ___ No ___

If yes, name of Therapist: _____

Phone: _____

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: _____

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/Breast Feeding
- Vasculitis
- Claustrophobia
- Hyperhidrosis - heavy perspiration
- Diabetes
- Inserted Aneurysm Clips in the brain

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, cotton underwear is the best choice). Women recommended: (swimsuit or shorts and top, cotton underwear and sport bra is the best choice). We will provide knee high socks, headband, gloves, face mask and clogs. 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 chamber.

This short duration of exposure would be safe even without the protective apparel. However, CYCLE & CRYO Body Mind 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. You will be directed to enter preliminary chamber first at the start of your treatment. When your time is up in the preliminary chamber; lights above the door and a ringing sound will alert you to enter the second chamber (the main chamber compartment). Please remember to pull hard to open doors (all doors are magnetic and are never locked!
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 but either yelling so that you can be heard or by simply exiting the chamber through the same way as you entered. Main chamber doors are Only for Emergencies.
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 CYCLE & CRYO Body Mind 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 CYCLE & CRYO Body Mind, 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 cryotherapy process, and I hereby release, indemnify and hold harmless CYCLE & CRYO Body Mind, 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 CYCLE & CRYO Body Mind, 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 New Jersey 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 cryotherapy 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 CYCLE & CRYO BODY MIND. I VOLUNTARILY AGREE TO EACH OF THE TERMS AND PROVISIONS HEREIN AND SIGN THIS OF MY OWN FREE WILL.

Printed Name

Signature

Date

Parent or Legal Guardian Signature

Date (mm/dd/yyyy)