CryoLabs

CRYOLABS MEDICAL QUESTIONNAIRE & CONSENT FORM

Name:..... D.O.B: ...../...../.....

Tel: ..... Email: .....

Parental/Guardian Consent if under 18: .....

Please indicate if you have or have had any of the following conditions:

Condition	Yes	No
Any known intolerance to cold		
Reynauds Disease		
Cancer		
Diabetes		
Hypothyroidism		
Sever Hypertension (BP > 180/100)		
Infection		
Fever		
Symptomatic Lung Disorders		
Severe Anaemia		
Acute or recent myocardial infarction		
Unstable angina pectoris		
Arrythmia		
Symtomatic cardiovascular disease		
Cardiac Pacemaker		
Peripheral Arterial Occlusive disease		
Croglonulinemia (Blood clotting disorder associated with extreme cold temperatures)		
Cold urticaria (Hives on the skin associated with extreme cold temperatures)		
Venous Thrombosis		
Pregnancy		
Acute or recent cerebrovascular accident		
Uncontrolled seizures		
Bleeding disorders		
Claustrophobia		

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BP Measurement Pre-treatment:
(NOTE: BP of 180/100 and above bars use of chamber)

1. All users of the chamber must wear appropriate clothing at all times consisting of:
a. Cotton shorts for men (or similar for women);
b. Sports support top for women (no underwired bras);
c. A face mask;
d. A hat or head band (to cover ears);
e. Cotton gloves;
f. Knee length socks; and
g. Clogs or similar footwear
2. All jewellery to be removed before treatment.
3. Participants must be completely dry before entering the chamber (including armpits, behind the knees and hair).
4. If any of the general medical questions were answered "Yes" treatment will not be possible without written authorization from your GP or medical consultant.
5. Participants must not touch each other or the walls, floor or ceiling inside the chamber.
If at any time you wish to end your treatment session before the allocated time please open the door of the main chamber and re-enter the pre-chamber and then open the door of the pre-chamber to leave the whole chamber.

Please answer the following question:	Yes	No
A full explanation of the process involving your treatment in the chamber from the operator has been completed and you acknowledge your understanding of the same.		

The information I have disclosed is accurate. I understand that I am free to revoke my consent at any time. I consent to the treatment of whole body Cryotherapy in the CryoLabs' chamber. This consent form covers future treatments of whole body Cryotherapy ay CryoLabs.

Signature:..... Date:...../...../.....

Witnessed by: .....
(Signature of staff member)

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