Client Information

DATE: _____

NAME: _____

ADDRESS: _____
Street City State Zip

EMAIL: _____

MOBILE#: _____ BIRTH DATE: _____

Have you tried whole body cryotherapy? Yes ☐ No ☐

How did you hear about Evergreen Cryotherapy? *(Circle applicable)*

Facebook *Google Search* *Twitter* *Instagram* *Post Card* *Drive-By* *Friend**

*Doctor** *Personal Trainer** *Explore Evergreen Magazine* *Evergreen Chamber of Commerce* *Other:* _____

*Who can we thank for referring you in? _____

Reason(s) for using cryotherapy. *(Circle all that apply)*:

Workout recovery *Improve athletic performance* *Pain management* *Decrease inflammation* *Increase energy* *Reduce depression/ anxiety* *Overall wellbeing*

Other: _____

Do NOT use Whole Body Cryotherapy if you have or may have any of the following conditions:
Pregnancy, Stage 2 Hypertension (BP> 160/100) according to American Heart Association, myocardial infarction, unstable angina pectoris, arrhythmia, symptomatic cardiovascular disease, cardiac pacemaker, peripheral arterial occlusive disease, venous thrombosis, acute or recent cerebrovascular accident, uncontrolled seizures, Raynaud's Syndrome, fever, tumor disease, symptomatic lung disorders, bleeding disorders, severe anemia, infection, claustrophobia, cold allergy, age less than 18 years (parental consent to session needed), acute kidney and urinary tract diseases. *If you have any other injury, illness or medical condition, you should consult your physician prior to using cryotherapy.*

Please alert staff of Evergreen Cryotherapy if there are any changes to your medical condition and/or treatment in subsequent visits.

I agree to pay for all services provided to me by Evergreen Cryotherapy. I agree to use all sessions and understand that refunds are not given on unused portions of purchased packages.

_____ _____

Client Signature **Parent/Legal Guardian Signature**