Initial Cryotherapy Disclaimer

Dear Patient,

Welcome to Gage Chiropractic Center. To insure your comfort, health, and safety throughout your visit, we sincerely ask you for a moment of your time to fill in the following questionnaire and sign the release and waiver of liability. We are committed to protecting your privacy. We store and use your data strictly for the purposes related to your visit and use of our services. Your data is confidential, and it is not shared with any third parties.

Patient Information

Full Name: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____

Mobile Phone: _____ Email: _____

Emergency Contact: _____ Mobile Phone: _____

How did you hear about Gage Chiropractic Center? _____

Lifestyle/Health history

What is your main goal for using cryotherapy? _____

How would you rate your current stress level? (1=low, 5=high) _____

How would you rate your energy level? (1=low, 5=high) _____

How would you rate your sleep quality? (1=low, 5=high) _____

How often do you exercise? _____

How would you describe your diet? _____

Are you currently using any medications or undergoing any medical treatments? Yes No
If yes, please list:
_____
_____

Have you ***recently* undergone any of the following procedures?**

Cold treatments (cryo, ice pack, cold plunge)? Yes No

If yes, was it within the last 4 hours? Yes No

Tanning bed or sunbathing? Yes No Local Anesthetic ? Yes No

New Tattoo or New Piercing? Yes No Cupping or Accupuncture? Yes No

Beauty Treatments(slimming, liposuction, breast augmentation, Botox, fillers)? Yes No

Applied body lotion, oil, or any skin care product in the last hour? Yes No

Are you currently under the influence of alcohol and/or other substances? Yes No

Do you have, or have you had any of the following health conditions? (circle any that apply)

Cold or flu (fever) in the last week Dizziness/Shortness of breath Anxiety disorders Bloating

Diabetes Claustrophobia High blood pressure Low blood pressure Currently pregnant

Metal implants (plates, screws, pins) Arthritis Neuropathy Thyroid/hormonal imbalance/PCOS

Asthma/bronchitis/pneumonia Epilepsy/seizures/light sensitivity Varicose veins/thrombosis

Blood disorders(anemia, clotting, etc) Kidney or liver problems Palpitations or chest pain

Heart disease/stroke Pacemaker Circulatory problems Lymphatic infection

Autoimmune disease Raynaud's disease Cancer/tumor Low tolerance to cold

Open wounds/ulcers Gangrenous lesions Agammaglobulinemia

The use of the whole-body cryotherapy chamber requires the use of ALL of the below listed PPE's at the timing of entering the cryo session as well as at ALL times during the session:

-Shoes/boots/slides and Socks
-Underwear (must not contain any metal components)
Bottoms for males. Tops and bottoms for females. (absolutely NO nudity permitted)
-Gloves

Initial Here:_____

Any body part or body surface that is exposed to nitrogen vapors must not have any metal in contact with it. This includes all piercings.

Initial here:_____

Any body part or body surface that is exposed to nitrogen vapor must be dry and not have any lotion on it at the time of treatment.

Initial here:_____

RELEASE AND WAIVER OF LIABILITY

In consideration of being permitted by Gage Chiropractic Center to use their services, I hereby release, waive, discharge, and hold harmless Gage Chiropractic Center, it's office, employees, owners, and contractors from any and all claims, liability, demands, actions and causes of action whatsoever arising out of or related to any loss, damage, or injury that may be sustained while using the services/products/ equipment or due to the use of such. I hereby confirm that no warranty or guarantee has been made to me covering the results of Gage Chiropractic Center services or products. 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/service. I am fully aware of the risks and hazards connected with Gage Chiropractic Center products/services, including the risk of skin irritation and other injuries. I am voluntarily participating in the use of the services and voluntarily assume full responsibility for any risk of loss, property damage, or personal injury that may be sustained. It is my express intent that this Release and Waiver of Liability Agreement shall bind the members my family and my heirs, assignees, and personal representatives. My signature below constitutes my acknowledgement that Gage Chiropractic Center services have been fully explained to me and I hereby give my authorization and consent to Gage Chiropractic Center to

proceed with the treatments. This Release and Waiver of Liability Agreement shall stand as long as I use the services/products at Gage Chiropractic Center premises now and in the future. I have read the instructions for proper use of the facilities and do so at my own risk.

NOTICE

You are free to end your session at any time during the treatment by simply advising the Gage Chiropractic Center staff. Any change in your medical history between treatments must be without delay (latest before the next session) declared to the Gage Chiropractic Center staff. The Gage Chiropractic Center staff reserves the right to refuse to render services in case of such a change or may require a prior written recommendation from you physician. Gage Chiropractic Center is not responsible for any of your personal belongings left behind or lost.

PATIENT SIGNATURE

By signing this document, I acknowledge and represent that I have read, fully understand, and agree with all of the above. I am at least 18 years of age, fully competent and signing this document voluntarily. Furthermore, I agree that I will comply with all instructions on the use of the equipment and that I am using Gage Chiropractic Center services at my own risk. I agree to use services within the terms and conditions of this document.

Date: _____

Patient Name: _____

Signature: _____

IF UNDER THE AGE OF 18

Legal Guardian Name: _____

Signature: _____

Gage Chiropractic Center witness: _____

We wish you an amazing experience!
Cool regards from the Gage Chiropractic Center Team