Name :	D.O.B :
Address:	
	Postcode:
Mobile: Landline:	
Email:	

Assessing Your Health (Please circle against any conditions that apply to you)

History

I Have Had:

A heart attack	**Yes / No**
Heart surgery	**Yes / No**
Cardiac catheterization	**Yes / No**
Coronary Angioplasty	**Yes / No**
Pacemaker/implantable cardiac defibrillator/rhythm disturbance	**Yes / No**
Heart valve disease	**Yes / No**
Heart failure	**Yes / No**
Heart transplant	**Yes / No**
Congenital heart disease	**Yes / No**

Symptoms

I experience chest discomfort with exercise	**Yes / No**
I experience unreasonable breathlessness	**Yes / No**
I experience dizziness, fainting , blackouts	**Yes / No**
I take heart medications	**Yes / No**

Other Health Issues

I have diabetes	**Yes / No**
I Have asthma or other lung disease	**Yes / No**
I have Peripheral vascular disease (PVD) or burning/cramping in my lower legs when walking short distances	**Yes / No**
I am pregnant	**Yes / No**
I have epilepsy	**Yes / No**

I have a chlorine allergy	**Yes / No**
I have Raynaud's disease	**Yes / No**
I have Cryoglobulinemia or other cold allergies	**Yes / No**

If you have marked any of the statements in this section, you must consult your doctor or appropriate healthcare provider before undertaking a Cryospa session

Cardiovascular risk factors

I am a man older than 45 years	**Yes / No**
I am a woman over 55 years, I have had a hysterectomy	**Yes / No**
I smoke or quit within the last 6 months	**Yes / No**
Do you suffer from high or low blood pressure	**Yes / No**
I take BP medication	**Yes / No**
Do you suffer from high cholesterol or low cholesterol	**Yes / No**
I have a close blood relative who had a heart attack before the age of 55 (Father/brother) or 65 (mother/sister)	**Yes / No**
I am physically inactive	**Yes / No**

If you marked 2 or more of the statements in this section yes, you must consult your doctor or appropriate healthcare provider before undertaking a CryoSpa session

Contraindications Checklist

Skin allergy	**Yes / No**
Broken skin/ open wound	**Yes / No**
Abnormal / altered skin sensation	**Yes / No**

If you have marked yes to any of the above, you may not proceed with treatment

If you have temporary minor illness such as sore throat, cold, flu etc you should postpone your CryoSpa session and rebook for a future date.

I confirm that the answers on this form, at today's date, are correct to the best of my knowledge and belief.

I undertake to notify Bodyscape Health Club of any changes to the information given on this form, when booking future CryoSpa sessions.

Signature

Date

Relationship to applicant if signing for an under 18

Bodyscape Health Club will keep this information on sensitive record for a 3-year period