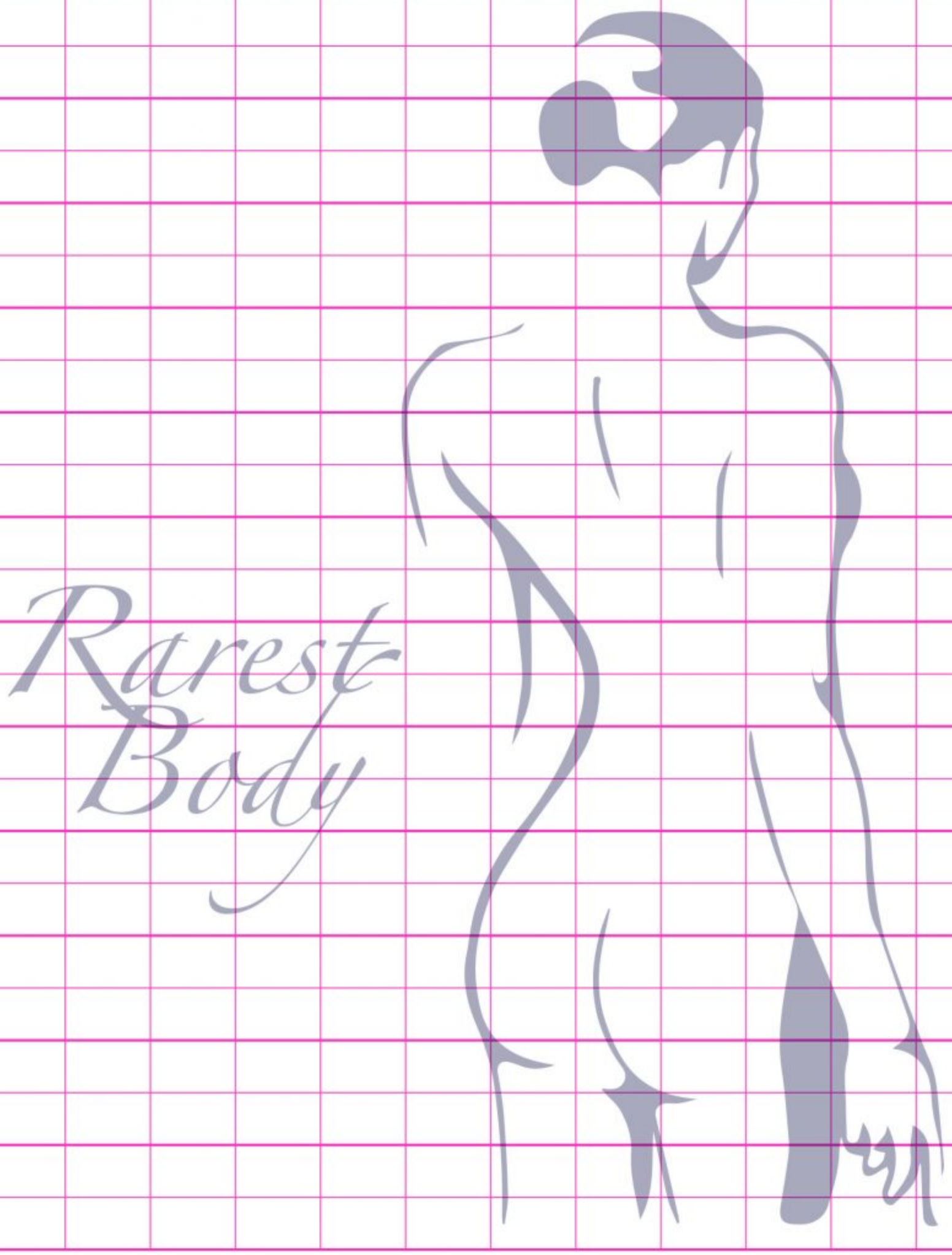
VF 100

CRYOFIT THERAPY

CUSTOMER'S NAME AND SURNAME

Procedure no.	Body measures	Weight	Waist	Stomach	Hips	Thigh right	Thigh left	Knee right	Knee left	Calf right	Calf left	Hand right	Hand left	Total (cm)
1.	Before													
	After													
2.	Before													
	After													
3.	Before													
	After													
4.	Before													
	After													
5.	Before													
	After													
6.	Before													
	After													
7.	Before													
	After													
8.	Before													
	After													
9.	Before													
	After													
10.	Before													
	After													
11.	Before													
	After													
12.	Before													
	After													



The client agrees that he/she is informed about the protocol of the procedure until the desired results are achieved, as well as about the precautions before and after the procedure.

SIGNATURE _____