



USCryotherapy

FASTER RECOVERY • BETTER HEALTH

Client: Amita Garadi (6498)

Dec 15, 2025

1. Please note: fields with a red asterisk are mandatory.

Legal First Name: <u>Amita</u>	Legal Last Name: <u>Garadi</u>	Date of Birth: <u>5/27/1984 (age 41)</u>	
Minor's Guardian Full Name, If Applicable: _____	Gender: <u>Female</u>	Street Address of Residence: <u>3642 Pontina Ct</u>	Apt./Unit #: _____
City of Residence: <u>Pleasanton</u>	State of Residence: <u>CA</u>	Zip Code: <u>94566</u>	Mobile Phone: <u>(310) 963-2648</u>
Email: <u>aypatel527@gmail.com</u>			

2. The client allows MedScape GFE to perform the good faith exam and for the good faith exam to be released to:
US Cryotherapy Danville/San Ramon

Appointment made?
Yes

3. Please state the date and time of the appointment:

12/20 @ 12pm

4. Check all treatments to have now or possibly would like in the future below: *Note: MedScape GFE does not determine the treatment route and/or dosages nor prescribes. US Cryotherapy Danville/San Ramon advises on treatment options within their clinic, scope of practice and protocols according to their medical director's guidelines.

☒ T-Shape 2 Cellulite
Reduction and/or Skin
Tightening

5. Please answer the questions below relating to the selected treatment(s) above:

Have had selected treatment(s) before?
No

Result of previous treatment(s)?
Not applicable

Goal of requested treatment(s)? Select ALL that apply.
☒ Tighten Skin

If needed, please explain further below:

6. Under any type of medical care? (i.e. PCP, OB/GYN, allergist, naturopath, mental health, specialist)

Yes

7. "Yes" for medical care was selected. Please list the provider's name(s) and their speciality.

	Name	Speciality
1	Tulika Gosh	PCP

8. For female assigned gender at birth:

Currently pregnant? ☒ No

Trying to become pregnant? ☒ No

Could possibly be pregnant? ☒ No

Currently breastfeeding? ☒ No

Going through IVF/Planning on IVF in the near future? ☒ No

9. List ALL medications below including homeopathic supplements and vitamins. If none apply, please write in "none".

	Name of Medication and Dose:	Start Date:
1	Levothyroxine	2004

10. List ALL surgeries and hospitalizations below. This includes ALL implantation of objects placed in the body that one is not born with ie devices, stents, piercings. If none apply, please write in "none".

	Type of Surgery/Hospitalization/Implant and Location:	Date and Year of Surgery/Hospitalization/Implant:
1	C section	10/2020
2	C section	11/2022
3	High BP post c section	11/2022

11. List ALL allergies below and/or dietary restrictions. If none apply, please write in "none".

	Type of Allergy:	Reaction:
1	None	

12. Vitals & Measurements

Height (ft/in or cm)

5.175 ft

Weight (lbs or kg)

129

Have you noticed any recent changes in your weight?

Yes

Do you have personal wellness or body goals you'd like us to know about?

Lose 10 pounds - have a lot of weight gain in abdominal area

If "other", please specify

13. Health History - Circulatory and Respiratory System (Please select all that apply):

☒ Asthma

14. Health History - Nervous System (Please select all that apply):

☒ None of these

If "other", please specify

15. Health History - Digestive System (Please select all that apply):

☒ None of these

If "other", please specify

16. Health History - Skin (Please select all that apply):

☒ None of These

If "other", please specify

17. Health History - Other (Please select all that apply):

☒ Hypothyroidism

If "other", please specify

18. Health History - Cancer

Have you ever been diagnosed with cancer?

No

Has any immediate family member (parents, siblings, children) been diagnosed with cancer?

Yes

If "other", please specify

If yes, please specify type, date of diagnosis, and current status (active, in remission, or treated) N/A for No.

Na

If yes, Please specify relation, type of cancer, and age at diagnosis. N/A for No.

58- metastatic thyroid, 69 - breast

19. Health History - Mental Health & Emotional Well-Being

Do you have a history of depression, anxiety, or other mental health conditions?

No

If yes, are you currently receiving treatment (medication, counseling, or therapy)? N/A for none.

Na

Have you ever been hospitalized for a mental health condition?

No

If "other", please specify

If yes, please specify when and which hospital. N/A for none.

20. Health History - Sexual Health & Hormones

Do you experience sexual dysfunction (low libido, erectile difficulties, vaginal dryness, or other concerns)?

No

Have you noticed changes in your energy, mood, or sleep patterns that you think may be hormone-related?

Yes

Would you like to have a hormonal evaluation via lab work?

Yes

If "other", please specify

If yes, please specify. N/A for none.

Na

Have you ever had a hormone evaluation (testosterone, estrogen, thyroid, cortisol, etc.)?

No

21. Health History - Hair & Skin Health

Do you currently experience hair loss, thinning, or shedding?

No

Would you like a consultation about hair loss?

No

If "other", please specify

Eczema

Have you tried any treatments for hair loss in the past?

No

Do you have a history of skin disorders (acne, eczema, psoriasis, etc.)?

Yes

22. Please answer the lifestyle questions below:

Average stress level:

High

On average, how many days per week for alcohol consumption?

Weekends only

On average, how many glasses of fluids (including water, juice, and decaffeinated tea) are consumed daily? (Glass = 8 ounces)

More than 8 glasses

Smoke, vape, or chew tobacco?

None

Recreational drugs?

None

Currently following any specific diet plan? If so, please specify which one(s): ☒ **None of these**

23. Approval and/or deferral to medical director's SOPs (description of treatment(s) that client is approved and/or deferred for). Please select all that apply treatments for approved and/or deferred to medical director's SOPs with US Cryotherapy Danville/San Ramon. MedScope GFE does NOT condone any off label administration or dosing of

ANY treatments. We will approve, however, it is ONLY depending on if US Cryotherapy Danville/San Ramon medical director allows for off label treatment(s). For any off label administration and dosage, US Cryotherapy Danville/San Ramon must follow policies and procedures as approved by your clinics medical director. If US Cryotherapy Danville/San Ramon medical director does not allow for said off label treatment(s), the good faith exam note provided by MedScape GFE's and the high-level provider will be null and void.

Treatment(s) client is approved and/or deferred to receive treatment at US Cryotherapy Danville/San Ramon (select ALL that apply to visit): ☒ **Approved for T-Shape 2 Cellulite Reduction and/or Skin Tightening**

Treatment(s) deferred to US Cryotherapy Danville/San Ramon medical director's SOPs with the reason(s) for deferral. If no explanation(s) is/are necessary, please write "not applicable":

NA

Clarification(s) needed from the client before approval. The client MUST resubmit with clarification(s) requested by the good faith exam high-level provider. If the client does not provide what the good faith exam high-level provider requests, the note is void, and therefore, the client is denied. If no explanation(s) is/are necessary, please write "not applicable":

NA

Term(s) of approved treatment(s) (select ALL that apply):

☒ **1 year (unless medical condition(s) change, medication(s) change and/or anything if anything is added to what is stated and approved in this GFE. If any of the aforementioned apply, the client must be re-seen at the time of discovery AND before their next appointment/treatment(s)**

Provide treatment name(s) and explanation(s) for short-term approval(s) (under one year approval). If no explanation(s) is/are necessary, please write "not applicable":

NA

e-signature

Dec 15, 2025

Good Faith Exam completed by the following MedScape GFE Practitioner:

Danielle Trenelli, FNP-BC

Signed by Danielle Trenelli on Dec 15, 2025 at 04:33 PM from IP 71.127.239.***