The Dartmouth SPA

# Personal Spa Treatment Consultation

PRIVATE AND CONFIDENTIAL

Mr/Mrs/Ms/Miss/Dr Full Name: ..... Group Name/Spa Type: .....

Address: .....

..... Postcode: .....

Email: .....

.....

Date of Birth: ..... Home Tel: .....

Occupation: .....

Where Did You Here About Us: .....

Would you like to be invited to future beauty spa events YES / NO

## MEDICAL INFORMATION

Please provide the following information for our records. If you have any health condition (whether or not listed below) we recommend that you proceed only with your doctors approval.

Are you currently under a doctor's care and receiving ongoing treatment? .....
*(If yes please specify)*

Please list any medication or homeopathic supplements that you are currently taking .....
*(Please give name and purpose)*
.....

.....

- ☐ High/low blood pressure
- ☐ Heart condition/strokes/pacemaker
- ☐ Cancer/chemotherapy/radium
- ☐ Kidney/liver disorders
- ☐ Thrombosis
- ☐ Varicose veins/DVT
- ☐ Hepatitis
- ☐ Thyroid problems
- ☐ Haemophilia
- ☐ Respiratory problems I.E. Asthma
- ☐ Recent surgery (past 12 months)
- ☐ Pregnancy/IVF/breast feeding
- ☐ Haemorrhaging
- ☐ Hormonal imbalance
- ☐ Depression or anxiety
- ☐ Diabetes (type 1 or 2)
- ☐ Arthritis/rheumatism/osteoporosis
- ☐ Prosthesis/metal pins/plates/piercings
- ☐ Muscular pain
- ☐ Skin disorders/diseases
- ☐ Water retention/odema
- ☐ Poor circulation
- ☐ Acute or chronic back pain
- ☐ Skin sensitivity/allergies
- ☐ Migraine
- ☐ Ear/nose/throat infection
- ☐ Foot infections
- ☐ Claustrophobia
- ☐ Hepatitis B or C
- ☐ Epilepsy

List any health information that may affect or prevent you having a treatment .....

.....

On a scale of 1 to 5 how stressed do you feel? (1 = Not stressed, 5 = Very stressed) 1 2 3 4 5

## FACIAL TREATMENTS

What is your daily facial routine? .....

What are your 3 main concerns with your skin? Please tick

- ☐ Ageing
- ☐ Fine lines
- ☐ Dryness
- ☐ Lack of radiance
- ☐ Redness
- ☐ Sensitivity
- ☐ Open pores
- ☐ Oily
- ☐ Acne
- ☐ Congestion
- ☐ Dark circles
- ☐ Other

## BODY TREATMENTS

What are your 3 main concerns with your body? Please tick

- ☐ Difficulty relaxing
- ☐ Muscle tension
- ☐ Muscle cramps
- ☐ Poor circulation
- ☐ Lethargic
- ☐ Water retention
- ☐ Cellulite
- ☐ Loss of firmness
- ☐ Weight loss
- ☐ Weight gain
- ☐ Stretch marks
- ☐ Dry skin
- ☐ Skin conditions (eczema, proriasis etc)

## MASSAGE

What massage pressure do you prefer? Light, medium, firm .....

## PATCH TESTING

For safety purposes certain treatments, for example eyelash tinting, require patch testing to be carried out 18 hours or more in advance. Our therapists are not permitted to provide these treatments if patch testing has not been undertaken.

## YOUR PERMISSION

I hereby consent to the use of my personal data (including any sensitive personal data) for the purpose of my treatment and any future treatment and confirm that any treatment is at my own risk without limiting or affecting any statutory rights I may have. I agree that any dispute or claim that arise out of, or is related to, such treatment and/or spa services shall be subject to the law and the exclusion jurisdiction of the courts of the country/region in which the relevant treatment/service took place.

I have read, understood and agree with the above information and have no objections to the treatment provided.

Client Signature..... Date.....

Therapist Signature..... Date.....

I do hope you enjoy your time with us at Dartmouth Spa. Should you have any questions or requests during your time with us please do not hesitate to ask a member of the Spa team.

☐ Please tick this box if you do not wish to receive any future marketing promotions from us.

The Dartmouth SPA