

## Spa Consultation Form

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Contact Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Doctors Address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Is this your first visit to Cloud Nine Spa? Yes ( ) No ( )

### Do you suffer from any of the following medical conditions?

- Allergies             Asthma             Back Problems             Nerve Damage  
 Diabetes             Cancer             Loss of sensation             High/Low Blood Pressure  
 Epilepsy             Other

If yes please give details \_\_\_\_\_

### Are you going through any of the following?

- Pregnancy             Breast Feeding             Pain in any area             Headaches/Migraines  
 Other

If yes please give details \_\_\_\_\_

### Medical History? (If yes, please detail):

Are you on any Medication? Y/N \_\_\_\_\_

Is there history of family illness? Y/N \_\_\_\_\_

Have you had any recent surgery, accidents or injuries? Y/N \_\_\_\_\_

### Skin Type and Concerns:

- Normal             Dry             Combination             Oily             High Colour  
 Sensitive             Sun Damage             Lines/Wrinkles             Dark Circles/Puffiness

Other \_\_\_\_\_

### Body Concerns:

- Dry Skin             Cellulite             Poor Circulation             Aches/Pains

Other \_\_\_\_\_

### Massage Pressure:

- Light             Medium             Firm             Deep

How would you like to feel after your Treatment? \_\_\_\_\_

### CONSENT AND AGREEMENT

I certify that the above statements are true and correct therefore I give my consent and authorization for my treatment to be carried out.

Client Signature: \_\_\_\_\_ Date \_\_\_\_\_

Therapist Signature: \_\_\_\_\_ Date \_\_\_\_\_