dream
spa & salon

CLIENT CONSULTATION FORM

Name: _____

Email: _____

Mobile: _____ Home: _____

Date of Birth: (D/M) _____ Today's Date: _____

This Consultation Form will assist your therapist in correctly evaluating your needs & choosing the correct treatment for you today. All information is strictly confidential & remains the property of Dream Spa & Salon.

Please indicate any recent or current experience of the following conditions:

MUSCULAR/JOINT

- ☐ Recent/Repetitive Injury
- ☐ Joint Immobility
- ☐ Numbness/Tingling
- ☐ Pain/Swelling
- ☐ Fibromyalgia
- ☐ Arthritis
- ☐ Inflammation
- ☐ Whiplash

HIGH RISK

- ☐ Surgery
- ☐ Heart Problem/Pacemaker
- ☐ High/Low Blood Pressure
- ☐ Digestive Problems
- ☐ Diabetes or Epilepsy
- ☐ Cancer/Remission

ILLNESS/TENSION

- ☐ Cold/Flu/Virus
- ☐ Chest/Breathing
- ☐ Asthma
- ☐ Headaches
- ☐ Dizziness
- ☐ Sleeping Problems
- ☐ Depression
- ☐ Anxiety

CIRCULATORY

- ☐ Blood Clots
- ☐ Thrombosis
- ☐ Varicose Veins
- ☐ Edema
- ☐ Bruising
- ☐ Gout

Please list any physical or health conditions that your therapist should be aware of:

_____

Please list any medication taken regularly and any specific medication/pain killers taken today:

_____

What would you like to gain from your treatment today? _____

_____

FACE & BODY

- ☐ Allergies
- ☐ Pregnant/Breastfeeding
- ☐ Botox/Dermal Fillers
- ☐ Contact Lenses
- ☐ Post Natal/Pre Menstrual
- ☐ Chemical Peels
- ☐ Skin Sensitivity
- ☐ Menopausal
- ☐ Retin-A/Retinol
- ☐ Claustrophobia
- ☐ Heat Sensitivity

MASSAGE

Does your main occupation include: ☐ Desk/Computer Work ☐ Physical Activities ☐ Travel

Have you had a massage before? ☐ No ☐ Yes – when last? _____

What type of massage would you prefer today? ☐ Relaxing ☐ Remedial

Focus Areas: ☐ Full Body ☐ Upper Body ☐ Lower Body ☐ Hands & Feet ☐ Scalp/Sinus

Pressure: ☐ Light ☐ Medium ☐ Firm ☐ Deep ☐ With Trigger Point

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CLIENT CONSULTATION FORM (CONTINUED)

SKINCARE

Have you had a facial before? ☐ No ☐ Yes – when last? _____

What would you like to focus on today? ☐ Hydration ☐ Firming ☐ Exfoliation ☐ Extraction

GENERAL

Are you allergic to any of the following: ☐ Nuts ☐ Latex ☐ Other:_____

What type of exercise are you doing regularly: _____ Hours per week_____?

How do you feel today? ☐ Energetic ☐ Relaxed ☐ Tired ☐ Stressed ☐ In Pain

How were you referred to us? ☐ Word of Mouth ☐ Website/Internet ☐ Drive/Walk By ☐ Event

Please agree to the terms and conditions below:

☐ I confirm that to the best of my knowledge, the answers I have given are correct and I have not withheld any information that may be relevant to my treatment. I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform my Therapist of my current medical or health conditions and to update this history as a current medical history is essential her/him to execute appropriate treatment procedures.

I understand that the Dream Spa & Salon reserves the right to charge for appointments cancelled or broken without 24 hours notice.

Client Signature: _____ Date: _____