

SPA CONSULTATION FORM

Guest's Name:

Date:

Therapist's Name:

Treatment:

This Health Questionnaire 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

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

| Muscular/Joint | High Risk | Illness/Tension | Circulatory |
|---|--|--|---|
| <input type="checkbox"/> Recent/Repetitive Injury | <input type="checkbox"/> Surgery | <input type="checkbox"/> Cold/Flu/Virus | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Joint Immobility | <input type="checkbox"/> Heart Problem/Pacemaker | <input type="checkbox"/> Chest/Breathing | <input type="checkbox"/> Thrombosis |
| <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Asthma | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Pain/Swelling | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Headaches | <input type="checkbox"/> Oedema |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Diabetes or Epilepsy | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Bruising |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer/Remission | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> 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 SECTION

| | | | |
|---|---|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Contact Lenses | <input type="checkbox"/> Skin Sensitivity | <input type="checkbox"/> Claustrophobia |
| <input type="checkbox"/> Pregnant/Breastfeeding | <input type="checkbox"/> Post Natal/Pre Menstrual | <input type="checkbox"/> Menopausal | <input type="checkbox"/> Heat Sensitivity |

MASSAGE SECTION

- Does your main occupation include: ☐ Desk/Computer work ☐ Physical Activities ☐ Travel
- Have you had a massage before? ☐ No ☐ Yes – when last _____ ☐ Have Bodywork Regularly
- 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 Points

GENERAL SECTION

- How many glasses of water _____ caffeinated drinks _____ do you drinking a day?
- What type of exercise are you doing regularly _____ hrs per week _____?
- How do you feel today ☐ Energetic ☐ Relaxed ☐ Tired ☐ Stressed ☐ In Pain

- Please note it is not advisable to have a treatment if you have a fever, cold or flu symptoms.**

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.

If you are from NZ and would like to receive updates on our local spa promotions please supply your

Email Address

Guest Signature