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_____