THE MINERAL SPA

GENERAL CONFIDENTIAL HEALTH FORM

☐ MR ☐ MRS ☐ MS

GUEST NAME:

ADDRESS:

CITY: STATE: POSTCODE:

PHONE: EMERGENCY CONTACT (Optional):

EMAIL:

DATE OF BIRTH:

☐ I DO NOT WISH TO RECEIVE PROMOTIONS/SPECIAL OFFERS MATERIAL ETC

OCCUPATION: SPORTS ACTIVITIES:

Privacy Disclosure: This information is collected to provide our therapist with your treatment history to ensure continuity of therapy. There are some treatments which cannot be performed on clients with certain medical conditions. Please contact us prior to your treatment date if you have any of the following: pregnancy, shingles, hepatitis, cancer, blood clots, AIDS/HIV.

GENERAL HEALTH

1. Please tick if you currently have or have had any of the following symptoms/conditions in the last 12 months:

☐ Allergies ☐ Headaches/Migraines
☐ Asthma ☐ Heart Ailments
☐ Arthritis ☐ Hepatitis
☐ AIDS/HIV ☐ Herpes
☐ Blood Clots ☐ High Blood Pressure
☐ Cancer ☐ Insomnia
☐ Depression ☐ Kidney Ailments
☐ Dermatitis ☐ Low Blood Pressure
☐ Diabetes ☐ Osteoporosis
☐ Eczema ☐ Pregnancy
☐ Epilepsy ☐ Psoriasis
☐ Fatigue ☐ Shingles
☐ Haemophilia ☐ Varicose Veins
☐ Other

2. Are you currently taking any medications, herbs, vitamins?

☐ No ☐ Yes (Please specify)

3. Do you

☐ Smoke? ☐ Eat Spicy Foods?
☐ Exercise? ☐ Wear Contact Lenses?

4. How often do you consume alcohol?

☐ Regularly ☐ Seldom ☐ Never

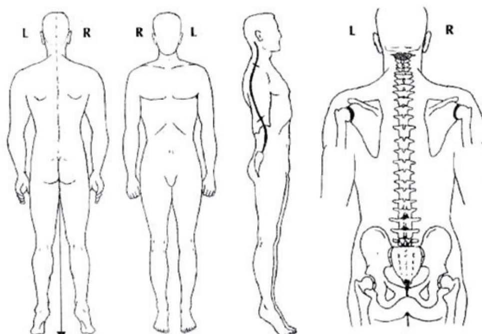
5. How many glasses of water do you consume daily?

☐ 1-2 ☐ 3-5 ☐ 6-8+

6. What massage pressure do you prefer?

☐ Light ☐ Medium ☐ Firm

Identify any specific areas of soreness and reasons if known



7. Do you have any body implants? ☐ Yes ☐ No

☐ Prosthesis ☐ Metal ☐ Other

8. Are you currently undergoing chemotherapy or radiation therapy? ☐ No ☐ Yes

9. If you could improve one thing about your skin, what would it be?

WOMEN ONLY

☐ Regular Menstruation ☐ Birth Control Pill
☐ P.M.S. Syndrome ☐ Menopause
☐ Hormonal Problems ☐ Lactating
☐ Pregnancy (How many weeks)

HOW DID YOU HEAR ABOUT US?

☐ Return Client ☐ Walk in ☐ Voucher ☐ Friends ☐ Peppers ☐ Dayget ☐ Local B&B ☐ Visitor Information Centre
☐ Conference ☐ Newsletter ☐ Google ☐ Yahoo ☐ TV ☐ Other

Would you like your therapist to discuss enhancing your treatment with our specially selected extra touches?

Vitamin enriched massage emulsion – for ultimate hydration ☐ Yes
Hair & scalp infusion to provide deep nourishment for your hair ☐ Yes
Eye soothe – reduces puffiness & dark circles ☐ Yes
Eye smooth – reduces fine lines & wrinkles ☐ Yes
Lip de-aging – smoothes & plumps lip contours ☐ Yes
Escutox – vegetal botox facial booster to relax and soften wrinkles ☐ Yes

I confirm and agree that any treatment is at my own risk, other than in relation to any physical or mental harm I suffer due to negligence, and without limiting or affecting any statutory rights I may have. The treatments provided are not medical treatments and should not be construed as such. Mineral Spa does not offer nor provide medical advice and should you have any concerns, we would urge you to obtain medical advice from a trained medical professional.

Guest Signature: Date:

MS Form General Health 2012 03

FACIAL ANALYSIS*

*For an effective personalised treatment, please be as accurate as possible.

10. Have you ever been prescribed Accutane
    - ☐ Yes ☐ No

    If yes, last date used?

11. Skin Type
    - ☐ Normal ☐ Combination
    - ☐ Dry ☐ Oily

12. What are you present skin care concerns?
    - ☐ Acne ☐ Sensitivity
    - ☐ Ageing ☐ Enlarged Pores
    - ☐ Rosacea ☐ Sun damage
    - ☐ Dilated Capillaries ☐ Pigmentation
    - ☐ Breakouts ☐ Blackheads

    Eye Area
    - ☐ Crows Feet/Wrinkles ☐ Puffiness
    - ☐ Lack of Elasticity ☐ Dark Shadows

    Mouth Area
    - ☐ Hyperpigmentation ☐ Wrinkles

    Cheek Area
    - ☐ Loss of Elasticity ☐ Dilated Pores
    - ☐ Uneven Texture ☐ Visible Capillaries

    Neck & Décolleté Area
    - ☐ Wrinkles
    - ☐ Lack of Elasticity
    - ☐ Severe Sun Damage
    - ☐ Hyperpigmentation

13. If you have ever had an allergic reaction to a skin care product, please describe the reaction and the product.

14. Have you recently received any of the following spa services?
    - ☐ Microdermabrasion Date
    - ☐ Enzyme Peels Date
    - ☐ Acid Peels Date
    - ☐ Waxing Services Date

15. Have you had surgery or any other invasive cosmetic procedures?
    - ☐ Yes ☐ No

    Please provide details:

16. Do you use any of the following?
    - ☐ Eye Make-up Remover Brand
    - ☐ Cleanser Brand
    - ☐ Lotion Brand
    - ☐ Moisturiser Brand
    - ☐ Exfoliant Brand
    - ☐ Mask Brand
    - ☐ Make-up Brand
    - ☐ Sunscreen Brand

17. How often do you receive a facial?
    - ☐ Regularly ☐ Seldom ☐ Never

BODY ANALYSIS

18. Have you received any of the following surgical procedures in the last 6 months?
    - ☐ Breast Augmentation ☐ Liposuction
    - ☐ Breast Reduction ☐ Tummy Tuck

19. Do you use any of the following products?
    - ☐ Body Scrub Brand
    - ☐ Body Wash/Soap Brand
    - ☐ Body Moisturiser Brand
    - ☐ Body Firming Cream Brand
    - ☐ Bath Salts Brand

20. What are your present concerns?

    Dry and/or Flaky Skin
    - ☐ Elbows ☐ Arms ☐ Back
    - ☐ Legs ☐ Knees ☐ Feet

    Oily Skin and/or Breakout
    - ☐ Back ☐ Chest

    Loss of Elasticity & Firmness
    - ☐ Buttocks ☐ Mid Torso ☐ Breasts
    - ☐ Inner Arms ☐ Mid Torso

    Cellulite
    - ☐ Thighs ☐ Buttocks ☐ Stomach

BOOKING NAME:

THERAPISTS NOTES (PROFESSIONAL USE ONLY)

DATE	THERAPIST	TREATMENT	HOME CARE