EXAMPLE CLIENT CONSULTATION FORM

Welcome to [NAME SPA | SALON]
Please read carefully, take time to fill out and sign this form with the requested information.
We look forward working with you.

Name _____

Email _____

Telephone _____

Phone _____

Date of Birth _____ ☐ Female ☐ Male

Are you currently affected by any of the following conditions?

(Rheumatoid) Arthritis? ☐ Yes | ☐ No
Osteoporosis? ☐ Yes | ☐ No
Sports injury (painful, swollen, hot etcetera)? ☐ Yes | ☐ No
Joint problems / Hyper Mobility? ☐ Yes | ☐ No
Muscular Aches / Pains? ☐ Yes | ☐ No
Do you suffer from chronic pain? ☐ Yes | ☐ No
Recent fractures or injuries to various, tissues, muscles, joints and spine? ☐ Yes | ☐ No
Post or recent (cosmetic) surgery? ☐ Yes | ☐ No
Recent scar tissue? ☐ Yes | ☐ No
Heart conditions, vascular diseases? ☐ Yes | ☐ No
Blood disorders ☐ Yes | ☐ No
Pacemaker or any metals in your body? ☐ Yes | ☐ No
Varicose veins / DVT? ☐ Yes | ☐ No
Fluid Retention / Oedema? ☐ Yes | ☐ No
High | Low blood pressure? ☐ Yes | ☐ No
Epilepsy ☐ Yes | ☐ No
Parkinson's disease ☐ Yes | ☐ No
Thyroid gland disorders ☐ Yes | ☐ No
HIV/AIDS ☐ Yes | ☐ No
Peacemaker or any metals in your body? ☐ Yes | ☐ No
Varicose veins / DVT? ☐ Yes | ☐ No
Fluid Retention / Oedema? ☐ Yes | ☐ No
High | Low blood pressure? ☐ Yes | ☐ No
Pneumonia or other respiratory disorders? ☐ Yes | ☐ No

Pregnancy / Breastfeeding? ☐ Yes | ☐ No
Depression / Anxiety? ☐ Yes | ☐ No
Claustrophobia? ☐ Yes | ☐ No
Sensitivity to heat ☐ Yes | ☐ No
Product Allergies? ☐ Yes | ☐ No
Skin Sensitivity? ☐ Yes | ☐ No
(Infectious) Skin conditions ☐ Yes | ☐ No
Fragile, broken or sunburnt skin ☐ Yes | ☐ No
Food/Nut Allergies ☐ Yes | ☐ No
Did you have recently aesthetic treatments (Botox, Fillers, Microdermabrasion, Chemical Peelings)? ☐ Yes | ☐ No
Open wounds? ☐ Yes | ☐ No
Foot infections? ☐ Yes | ☐ No
Alcohol or recreational drugs in your system? ☐ Yes | ☐ No
Do you smoke? ☐ Yes | ☐ No
Do you exercise regularly? ☐ Yes | ☐ No
Do you wear contact lenses? ☐ Yes | ☐ No
Do you wear dentures? ☐ Yes | ☐ No
Do you wear hearing aid? ☐ Yes | ☐ No
Do you have implants? ☐ Yes | ☐ No
Nausea/ Dizziness ☐ Yes | ☐ No
Fever / Flu Cold Virus /COVID? ☐ Yes | ☐ No
Cancer/Chemotherapy? ☐ Yes | ☐ No
Diabetes (type 1 or 2)? ☐ Yes | ☐ No

If you answered YES on any of the above questions, please specify:

Is there anything else you think we should know regarding your health which may effect preventing you having a treatment? ☐ Yes | ☐ No

If yes, please explain?

If you circled pregnancy, please complete the following questions:

1. Do you have any complications in this pregnancy?

2. Have you experienced any complications in previous pregnancies?

3. In which week of your pregnancy are you?

Are you currently taking any medications? ☐ Yes | ☐ No

If yes, please list including topical and oral:

Are you currently under the care of a health professional for injuries or on-going medical treatment? ☐ Yes | ☐ No

If yes, please explain:

Have you ever had any surgery? ☐ Yes | ☐ No

If yes, please explain:

Do you have any difficulty lying on your back, front or turning on your side? ☐ Yes | ☐ No

If yes, please explain:

Why have you chosen this treatment today?

What is your therapeutic priority for this treatment?

How much pressure do you prefer in your massage?

☐ Soft/Light ☐ Medium ☐ Hard/Deep

We reserve the right to perform any treatment until written permission is given by your medical professional if you have a medical condition.

Important note:

I choose to have a spa/wellness treatment and I understand that the information given above is strictly confidential. It will only be used to assist the therapist to develop a suitable treatment according to my specific requirements and needs so that the best results can be achieved. I hereby give consent for all future treatments based on information supplied, and I release (+[NAME SPA/WELLNESS PARTNER] and its staff) of any liability associated with any injuries and /or current and future conditions resulting from the treatment procedures or products. Please note that information provided by the therapist is for general educational purposes and is NOT intended for any medical or therapeutic purposes, but for information only. Your personal data will be held and used only by the spa, salon or wellness facility providing the treatment(s)

Client Signature: Date: Therapist Signature: Date: