spa & sport

CLIENT CONSULTATION FORM

Client Name: _____

Client Address: _____

Telephone: M_____ H_____ W_____

Email: (please be clear)_____

Birthday:_____ How did you hear about us? _____

If you are staying at the Swissotel Sydney, what is your Room No. _____

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Find us on Facebook

Instagram

General Health Information - Please tick all that apply

How would you best describe your health?

(Please circle) Excellent / Good / Poor

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

Muscular/Joint	High Risk	Illness/Tension	Circulatory
☐ Recent/Repetitive Injury	☐ Surgery	☐ Cold/Flu/Virus	☐ Blood Clots
☐ Joint Immobility	☐ Heart Problem/Pacemaker	☐ Chest/Breathing	☐ Thrombosis
☐ Numbness/Tingling	☐ High/Low Blood Pressure	☐ Asthma	☐ Varicose Veins
☐ Pain/Swelling	☐ Digestive Problems	☐ Headaches	☐ Oedema
☐ Fibromyalgia	☐ Diabetes	☐ Dizziness	☐ Bruising
☐ Arthritis	☐ Cancer/Remission	☐ Sleeping Problems	☐ Gout
☐ Inflammation	☐ Epilepsy contraindicated for LED light therapy	☐ Depression	☐ Anxiety

Do you:

☐ Smoke? ☐ Exercise Regularly? ☐ Follow a restricted diet? ☐ Consume caffeine daily? ☐ Sunbathe or use solariums?

Are you on any medication? If so, please specify: _____

Are you taking any specific supplements or vitamins regularly?

If so, please specify: _____

Have you been under a dermatologist's or physician's care within the last year?

☐ Yes ☐ No

If so, please specify: _____

Do you have any pre-existing skin conditions?

If so, please specify: _____

Are you pregnant or trying to become pregnant?

If so, please specify: _____

Massage Section

Does your main occupation include: □ Desk/Computer work □ Physical Activities □ Travel

Have you had a massage before? □ NO □ YES When Last _____

Focus Areas:

□ Full body □ Upper Body □ Lower Body
□ Hands & Feet □ Scalp/Sinus

What type of massage would you prefer today?

□ Relaxing Pressure: □ Light □ Medium
□ Therapeutic Pressure: □ Firm □ Deep

Skin Section

Please indicate your skin type:

□ Normal □ Dry □ Sensitive □ Combination □ Oily
□ Mature □ Sensitive/Breakout □ Acne □ Hypersensitive

Please indicate your main concern with your skin:

□ Ageing □ Hyper-pigmentation □ White Heads
□ Acne □ Rough texture □ Blackheads
□ Clogging □ Red Skin □ Sun Damage

Have you had or are you using?

□ Microdermabrasion □ LED Light therapy □ Laser □ Retin A
□ Glycol Acid Peels & Products □ Botox/Fillers

Do you use any of the following?

□ Cleanser □ Toner □ Exfoliator □ Moisturiser
□ Eye Product □ Sunscreen □ Mask □ Serum

Please list any current skin concerns: _____

How often do you have a facial treatment?

□ Regularly □ Seldom □ This is my first time

What would be the most important skin concern you would like to treat?

_____

What are your expectations? _____

☐ *I have read, answered, and understood the above questions and I confirm that the above information that I have provided is true, full and an accurate statement of my current physical and medical status.*

Acknowledgement & Consent to proceed with treatments

I understand that the all treatments are taken at my own risk and that the management of Spa&Sport at Swissotel Sydney and its employees assume no liability of any kind by participating with the treatment you have chosen.

Client Signature:_____ **Date:**_____