****

**Client consultation form**

**(These records get kept for 10 years after your last treatment)**

This consultation form assists your therapist in evaluating your needs & choosing the correct treatment for you. All information is strictly confidential.

**First Name……………………………………… Surname………………………………………………..**

**DoB……………………………Email……………………………………………………….……………..…Mobile………………………………………………. HomeTel……………………………………………..**

**Address……………………………………………………………………………………………………......…………………………………………………………………………………………………………………**

**Occupation…………………………………………………………………………………………………...**

**Height………………………………Weight…………………………………………………………………**

**GP (Doctors)**

**Name…………………………………………………………………… Address………………………………………………………………………………………………………**

**Tel……………………………………………………………………………………………………………**

**Next of Kin**

**Name……………………………………………Tel………………………………………………………**

**It is not advisable to have treatment if you have a fever, cold or flu, under the influence of alcohol or just consumed a heavy meal.**

Etiquette

* It is advised to have a shower/bath before massage as its beneficial to allow the oils to soak into the skin. afterwards.
* A Spa pedicure isn't a chiropodist treatment.  If you have very long toe nails it’s advisable to trim them, to make the file & polish easier and to be more relaxing for yourself.
* Late arrival for treatment may mean treatment time has to be reduced to full fill other client requirements.

**Terms & conditions below:**

I understand that Peak Relaxation reserves the right to charge the full amount of a prebooked treatment if 24 hours’ notice is not given. If Peak Relaxation has to cancel an appointment without 24 hours’ notice you will be given a FREE treatment as compensation.

Deposits & gift vouchers are non-refundable.

Signed……………………………………………….. Print Name……………………………….. Date……………………

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

|  |  |  |  |
| --- | --- | --- | --- |
| **Muscular / Joint** | **High Risk** | **Illness / Tension** | **Circulatory** |
| Repetitive Injury □ | Surgery □ | Cold/Flu/Virus □ | Blood Clots/haemorrhage □ |
| Joint Immobility □ | Heart Problem □ | Chest/Breathing □ | Thrombosis/embolism □ |
| Numbness/Tingling □ | Pacemaker □ | Asthma □ | Varicose Veins □ |
| Pain/Swelling/oedema □ | High/low blood pressure □ | Headache/Migraine □ | Oedema □ |
| Fibromyalgia □ | Diabetes □ | Dizziness □ | Bruising □ |
| Arthritis □ | Epilepsy □ | Sleeping problems □ | Gout □ |
| Inflammation □ | Cancer/Remission □ | Depression □ | Phlebitis (inflammation of a vein) □ |
| Whiplash □ | Diabetes □ | Anxiety/Stress □ | Nervous System dysfunction □ |
| Neck/Shoulder Strain □ |  | Eye Strain □ |  |

Do you have any of the following health conditions? General ailments/infectious diseases/skin disorders/cuts or abrasions/inoculations (vaccinations) …………………………………………………………………………………………………………………...

Have you got osteoporosis? Y/N

Have had a recent fracture or sprains?...............................................................................................

Any back, head or neck problems?.................................................................................................

Any allergies?......................................................................................................................................

What medication are you on?..............................................................................................................

Have you had surgery in the last six months? …………………………………………………………….

or recent scare tissue?........................................................................................................................

Do you have cysts/lumps? Y/N

Unstable blood pressure or heart disorders?......................................................................................

Do you have diabetes? Y/N

Dysfunction of nervous system?............................................................................

Skin disorders?......................................................................................................

Severe bruising? Y/N

Could you be pregnant? Y/N

Are you breast feeding? Y/N

Date of last period?..............................................................................................

Have you had an IUD (Coil) fitted in the last 12 weeks? Y/N

Have you had an allergic reaction to a previous treatment? What was the reaction and when?

……………………………………………………………………………………………………………………………………………………………………………………………………………………………………

**Facial, skin, waxing & tinting section**

|  |  |  |  |
| --- | --- | --- | --- |
| Allergies □ | Contact Lenses □ | Skin Sensitivity □ | Claustrophobia □ |
| Pregnant/Breast Feeding □ | Post Natal/Pre-Menstrual □ | Menopausal □ | Heat Sensitivity □ |
| Botox/Dermal Fillers □ | Chemical Peels □ | Retin-A/Retinol □ |  |

**Patch test date ………………………………. Client Sign………………………….**

**Patch Test Pass Y/N**

**Therapist sign and detail any reaction………………………………………………………………**

**Massage Section**

* Does your main occupation include? - Desk/Computer □ Physical Activities □ Travel □
* Have you had a massage before? Y/N
* What form of massage have you had before? (Deep Tissue/Swedish/Pre-blended Aroma/ Hot Stone
* What type of massage would you like today? Relaxing □ Stimulating □ Deep Tissue □
* What is your massage pressure preference Light □ Medium □ Firm □ Deep □ With Trigger Points

**Indian Head Massage**

* Have you had Indian Head Massage before? Y/N
* For Indian Head – Do you suffer from;

Anxiety, Stress, Depression, Sleeping problems, Headaches/Migraines, Neck/Shoulder strain, Eye strain, sinus problems, tinnitus,

TMJ Disorder (Jaw Pain), Dandruff, Hair loss, Premature greying, Psoriasis/eczema

**Nail Section**

What are your main nail concerns?......................................................................................

Do you have regular manicures/pedicures? Y/N

When was your last nail treatment?...................................................................................

What type of nail treatment did you have last? Natural/Gel/Overlays/Sculpting/Other?

**General Section**

Do you eat breakfast, if so what? .......................................................................................................

Do you eat fruit & veg? Y/N How many pieces?................................................................................

How many glasses of water do you drink a day?...............................................................................

How many caffeinated drinks do you drink a day?..............................................................................

How many units of alcohol do you drink per week? (e.g bottle of wine 10 units, 1 pint of beer 3 units)……………………………………………………………………………………………………………

Are you on a special diet?...................................................................................................................

Do you smoke? Y/N

How often do you exercise?...........................................

When & what? ………………………………………………………………………………………………..

............................................................................................................................................................

What time do you go to bed & get back up?.......................................................................................

How many hours sleep do you get?....................................................................................................

What is the quality of you sleep? Good/Medium/Poor

If your sleep is poor why do you think this is? …………………………………………………………….

How busy is your lifestyle on a scale of 1-5 (5 being the busiest)? …………………

Why?...........................................................................................................................................

On a scale of 1-5 (5 being the highest) how stressed are you?.......................

What activities do you do to realx?....................................................................................

How did you hear of Peak Relaxation?...............................................................

Would you like to receive Peak Relaxation Newsletter & Offers? If yes please sign………………….

Has doctor consent been requested by Peak Relaxation? Y/N

Have you now got written consent? Y/N Letter ref:-………………………Date……………………

If having Afternoon Tea or Lunch (as this is low risk this is not insured but registered with environmental health) please sign to confirm you know it’s not insured……………………………….

If coming on the 45mins Calton walk before your treatment is too low risk to be insured. Please sign to agree that any injury is not the responsibility of Peak Relaxation……………………………

I declare that the information given, is true and I have not withheld any information that may be relevant to my treatment. As far as I am aware I can undertake treatments with Peak Relaxation without any adverse effects. I am willing therefore to proceed. I understand that massage or other treatments are not a substitute for medical advice and/or treatment.

Signed…………………………………… Print Name………………………… Date……………………