

MR  MS  GUEST NAME: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_  
 CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ POSTCODE: \_\_\_\_\_  
 PHONE (H): \_\_\_\_\_ (M): \_\_\_\_\_  
 EMAIL: \_\_\_\_\_  
 DATE OF BIRTH: \_\_\_\_\_

PLEASE TICK TO RECEIVE PROMOTIONS/SPECIAL OFFERS 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:

- |                                      |  |
|--------------------------------------|--|
| <input type="checkbox"/> Allergies   | <input type="checkbox"/> Headaches/Migraines |
| <input type="checkbox"/> Asthma      | <input type="checkbox"/> Heart Ailments      |
| <input type="checkbox"/> Arthritis   | <input type="checkbox"/> Hepatitis           |
| <input type="checkbox"/> AIDS/HIV    | <input type="checkbox"/> Herpes              |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Cancer      | <input type="checkbox"/> Insomnia            |
| <input type="checkbox"/> Depression  | <input type="checkbox"/> Kidney Ailments     |
| <input type="checkbox"/> Dermatitis  | <input type="checkbox"/> Low Blood Pressure  |
| <input type="checkbox"/> Diabetes    | <input type="checkbox"/> Osteoporosis        |
| <input type="checkbox"/> Eczema      | <input type="checkbox"/> Pregnancy           |
| <input type="checkbox"/> Epilepsy    | <input type="checkbox"/> Psoriasis           |
| <input type="checkbox"/> Fatigue     | <input type="checkbox"/> Shingles            |
| <input type="checkbox"/> Haemophilia | <input type="checkbox"/> Varicose Veins      |
| <input type="checkbox"/> Other       |  |

2. Are you currently taking any medications, herbs, vitamins?  
 No  Yes (Please specify) \_\_\_\_\_

3. Do you  
 Smoke?  Eat Spicy Foods?  
 Exercise?  Wear Contact Lens?

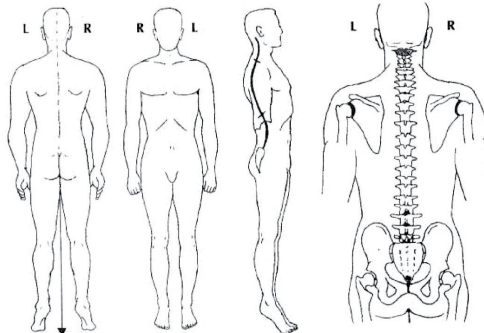
4. How often do you consume alcohol?  
 Regularly  Seldom  Never

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

- |   |   |
|---|---|
| <input type="checkbox"/> Regular Menstruation       | <input type="checkbox"/> Birth Control Pill |
| <input type="checkbox"/> P.M.S. Syndrome            | <input type="checkbox"/> Menopause          |
| <input type="checkbox"/> Hormonal Problems          | <input type="checkbox"/> Lactating          |
| <input type="checkbox"/> Pregnancy (How many weeks) |   |

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

- |   |                             |                              |
|---|-----------------------------|------------------------------|
| Vitamin enriched massage emulsion – for ultimate hydration          | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Hair & scalp infusion to provide deep nourishment for your hair     | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Eye soothe – reduces puffiness & dark circles                       | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Eye smooth – reduces fine lines & wrinkles                          | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Lip de-aging – smoothes & plumps lip contours                       | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Escutox – vegetal botox facial booster to relax and soften wrinkles | <input type="checkbox"/> No | <input type="checkbox"/> 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: \_\_\_\_\_

**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

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BOOKING NAME: \_\_\_\_\_

THERAPIST'S NOTES (PROFESSIONAL USE ONLY) \_\_\_\_\_

DATE \_\_\_\_\_ THERAPIST \_\_\_\_\_ TREATMENT \_\_\_\_\_ HOME CARE \_\_\_\_\_