Client Profile

the bannatyne SPA
www.bannatynespa.com

Client Details

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

Forename:

Surname:

Address:

Postcode:

Occupation:

Telephone (mobile):

Telephone (home):

Email:

Date of Birth: ☐ or confirm you are over 18 years of age

☐ Piercings/tattoos ☐ Epilepsy ☐ Diabetes ☐ Thrombosis/DVT* ☐ Hepatitis
☐ Cancer ☐ Sensitive Skin ☐ Claustrophobia ☐ Surgery in last 6 months ☐ Eczema/Psoriasis
☐ Prosthetics ☐ High/Low Blood Pressure ☐ Depression/anxiety ☐ Skin Infections ☐ Fungal Infections/Athletes Foot
☐ Heart Conditions ☐ Varicose Veins* ☐ Pregnancy ☐ HIV ☐ Allergies
☐ Intolerance to Heat

* Contra indications

If you have ticked any of the above please explain in more detail:

Lifestyle Questionnaire

Y	N	
☐	☐	Is your sleep disturbed?
☐	☐	Do you smoke?
☐	☐	Are you taking any medication?
☐	☐	Are you breastfeeding?
☐	☐	Do you exercise regularly?
☐	☐	Is there any history of family illness?

Medication

Please provide details of any medication taken

Please provide details of any other health issues that you feel are relevant?

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Facial Treatments

Treatment aims (pick 3)

- ☐ Brighter Skin
- ☐ Oil Control
- ☐ Deep Cleansing
- ☐ Anti-Ageing
- ☐ Soothing
- ☐ Nourishing
- ☐ Lifting

Body Treatments

Treatment aims (select what apply)

- ☐ Relaxation & Stress Relief
- ☐ Relieve Tired, Aching Muscles
- ☐ Reduce Cellulite
- ☐ Re-Defining
- ☐ Skin Nourishing
- ☐ Balancing
- ☐ Inch Loss
- ☐ Reduce Bloating/Water Retention

Do you follow a skin care regime at home?

☐ Yes ☐ No Please give details

Tint tests and lash extensions are required 48 hours before treatment otherwise treatment will be refused. Tick if you have had a Tint Test in the last 6 months at a Bannatyne Spa ☐

Treatment times include consultation and after care advice time.

Lateness for treatment will result in treatment being refused or time being shortened.

Client Signature: Therapist Signature:

Date: Date:

By completing this Client Profile and signing above, you will be indicating your consent to receiving email, text and postal marketing communications from us unless you have indicated an objection to receiving such communications by ticking this box ☐

Client History

Please indicate if anything has changed medically since your last treatment.

Date	Therapist	Treatment	Signature by Client to confirm nothing has changed