CONSULTATION FORM Client Details

Name: .....D.O.B:.....Email:.....

Address: .....

Telephone: ..... Are you happy for photos to be taken and used for marketing Yes ☐ No ☐

I give permission to have offers/newsletters sent to me via email/text Yes ☐ No ☐

Medical Details

Pregnant - under 12 weeks ☐ Diabetes ☐ Epilepsy ☐ High Blood Pressure ☐

Pregnant - over 12 weeks ☐ Breast Feeding ☐ Thrombosis ☐ Low Blood Pressure ☐

Varicose veins ☐ Claustrophobia ☐ Heart Condition ☐ Cancer/Chemo/Radio therapy ☐

Thyroid Condition ☐ Acne ☐ Eczema/Psoriasis ☐ Herpes ☐ Allergies ☐

Recent Surgery ☐ Recent Scar Tissue ☐ Other ☐

Details.....

Medication.....

I confirm that the information provided is correct and I understand that I am responsible for notifying my therapist if any of the information changes prior to treatment.

Client Signature: .....Date: .....

PRIOR TO THE START OF MY SERVICE, I CONFIRM THAT:

- I have not been diagnosed with or cared for someone diagnosed with COVID-19 in the past two weeks.
- I have not shown symptoms of COVID-19 or come in close contact with anyone exhibiting these symptoms in the past two weeks.
- I have not traveled outside of my immediate daily routine for the past two weeks.
- I do not have a cough, fever, chills, shortness of breath, or loss of taste or smell.
- If I begin to show symptoms of COVID-19 with the next two weeks, I will contact my therapist.
- I will follow all posted salon rules to keep myself, my therapist and those around me safe.

Signature .....

Printed Name .....

Date .....

Phone Number .....