

|  |
| --- |
| **Personal Details** |
| Name |
| Address |
| Date of Birth |
| Telephone |
| Mobile |
| Email |
| **Medical Details** |
| Allergies |
| Current Medication |
| Diabetes |
| Epilepsy |
| High/Low Blood Pressure |
| Heart Condition |
| Varicose Veins |
| Liver Issues |
| Kidney Issues |
| Stroke |
| Cancers |
| Major Operations/Surgery |
| Headaches/Migraine |
| Depression/Low Mood |
| Sleeping Problems |
| Hormone Irregularities |
| Digestive Issues |
| Claustrophobia |
| Skin Disorders |
| Asthma |
| Respiratory Problems |
| Rheumatism |
| Arthritis |
| Thrombosis |
| Joint Mobility |
| Muscular Aches/Pains/Numbness/Tingling |

|  |
| --- |
| **Skin Care** |
| Routine – Do you?* Cleanse
* Tone
* Exfoliate
* Use a Mask
* Moisturise
* Use a Serum/Oil
 |
| Do you usually wear make-up? |
| Do you have regular facials? |
| What are your main concerns? |
| Have you ever had?* Cosmetic Injectables
* Chemical Peels
* Microdermabrasion
* Resurfacing treatments
* Used products containing Retinol
 |
| Any other information |

|  |
| --- |
| **Massage** |
| How do you like the pressure during massage?* Light and Gently
* Medium
* Firm
 |
| Are there any areas that need extra attention? |
| Are there any essential oils you love? |
| Are there any essential oils you dislike? |
| Are you pregnant or breast feeding? |
| Any other information |