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| **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 |

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| **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 |

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| **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 |