Spa Consultation Form

Name: _____ **Date of Birth:** _____

Address: _____

Contact Number: _____

Email Address: _____

Is this your first visit to ***Salon Allure Hair, Nails & Spa****?* **Yes ( ) No ( )**

Do you suffer from any of the following medical conditions?

( ) Allergies
( ) Diabetes
( ) Asthma
( ) Back Problems
( ) High/Low Blood Pressure
( ) Other

If yes please give details: _____

Medical History? (*If yes, please detail*):

Are you on any medications? **Y/N:** _____
Is there a history of family illness? **Y/N:** _____
Have you had any recent surgery, accidents or injuries? **Y/N:** _____

Skin Type and Concerns:

( ) Normal ( ) Dry ( ) Combination ( ) Oily
( ) Sensitive ( ) Sun Damage ( ) Lines/Wrinkles ( ) Dark Circles/Puffiness

Other: _____

Body Concerns:

( ) Dry Skin ( ) Cellulite ( ) Poor Circulation ( ) Aches/Pains

Other: _____

Massage Pressure:

( ) Light ( ) Medium ( ) Firm ( ) Deep

CONSENT AND AGREEMENT

I certify that the above statements are true and correct therefore I give my consent and authorization for my treatment to be carried out.