MPS Health & Treatment Consultation Form

My Personal Sanctuary
The Visiting Spa Company

Full name: _____ Today's date: _____

Email: _____ Location: _____

Therapist's name: _____

Please tick all relevant boxes below

Today I am...

- ☐ Balanced & happy
- ☐ Tired & exhausted
- ☐ Physically drained
- ☐ Emotionally drained
- ☐ Needing to clear my mind

I would like to feel...

- ☐ De-stressed
- ☐ Deeply relaxed
- ☐ Rejuvenated & refreshed
- ☐ Detoxified

Massage Pressure...

- ☐ Light
- ☐ Medium
- ☐ Deep

My health today

Back / Spine / other Injuries

- ☐ Whiplash
- ☐ Trapped nerves
- ☐ Tendonitis
- ☐ Broken bones
- ☐ Frozen Shoulder
- ☐ Slipped disc
- ☐ Other (please give details):-

Under care of medical professional

- ☐ Doctor
- ☐ Osteopath
- ☐ Chiropractor
- ☐ Physiotherapist
- ☐ Acupuncturist
- ☐ Other (please give details):-

Medical Skin Conditions

- ☐ Eczema
- ☐ Asthma
- ☐ Psoriasis
- ☐ Acne
- ☐ Hypo-sensitive Skin
- ☐ Cuts & Abrasions

Medication

- ☐ I take medication
- ☐ I have taken it today
- ☐ Name/s:-

Allergies

- ☐ Asthma
- ☐ Flowers
- ☐ Alcohol
- ☐ Hay Fever
- ☐ Other (please give details):-

- ☐ Trying for a baby
- ☐ Pregnant no. of weeks: ☐

Recent / Chronic / Other Medical Conditions

- ☐ Diabetes
- ☐ Arthritis
- ☐ High blood pressure
- ☐ Thyroid
- ☐ Cancer
- ☐ Other (please give details):-

Anything else your therapist should know prior to treatment (continue on reverse if neccessary)

_____

DISCLAIMER: I understand that any treatments I receive are not a substitute for a medical diagnosis or treatment by a qualified medical practitioner. I understand that it is recommended that I see such a practitioner for any physical or psychological condition I have now or in the future. I further confirm that I have read, understood and completed the above to the best of my knowledge and that all details provided are true and accurate. I hereby release My Personal Sanctuary Ltd and its associated therapist/s from liability resulting from the use of equipment, materials, preparations, products or treatments and assume full responsibility for all risks in connection with this treatment (save for any personal injury or death caused by their negligence). I confirm that I am of lawful age and fully understand the contents of this form. I understand that failure to disclose information requested above may result in adverse side effects in respect of which I accept full responsibility. The undertaking of the treatment/s has been fully explained to me, and I fully understand the treatment/s or service/s to be carried out and complications which may arise or result during or following any procedure that is performed at my request. I accept that if I am not satisfied with the treatment I will inform the therapist giving them the opportunity to address the issue at the time and I will also inform My Personal Sanctuary on 01625 540 557 as soon as is practically possible.

IMPORTANT If you are under 16 years old a parent or guardian must consent & sign on your behalf. The parent or guardian must be present for the duration of treatment.

Guest or Parent/Guardian Signature: _____ Today's date: _____

Therapist's signature: Today's date: