Consultation Form

Title: Mr/Mrs/Ms/Miss Name: _____
Email Address: _____
Mobile: _____ Home Telephone Number: _____
Date of Birth: _____ Hotel Resident: ☐ Day Guest: ☐

Reason for your visit: _____
Where did you hear about us? _____
Occupation: _____

Medical Information

Please tick any of the following that applies to you:

☐ Diabetes	☐ Recent scar tissue	☐ Arthritis
☐ Epilepsy	☐ Metal pins and plates	☐ Eczema
☐ High/low blood pressure	☐ Thrombosis	☐ Dermatitis
☐ Heart conditions	☐ Muscle problems/injuries	☐ IBS
☐ Pacemaker	☐ Skin diseases	☐ Wart/Verruca
☐ Poor circulation	☐ Fungal infections	☐ Athletes foot
☐ Undiagnosed lumps	☐ Psoriasis	☐ Claustrophobia
☐ Cancer (In the last 5 years)	☐ Prescribed medication	☐ Depression

If you have ticked any of the above, please give details _____
_____

Any other medical conditions? _____
_____

Have you had an operation in the last 12 months? Yes/No
If you have circled yes, please give details _____
_____

Do you suffer from any allergies or have you ever had an allergic reaction? Yes/No
If you have circled yes, please give details _____

Ladies only
Please inform your therapist if you are pregnant so the correct treatment can be advised and carried out. Treatments can only be carried out from 12 weeks – 32 weeks.

Are you pregnant? Yes/No If yes, how many weeks? _____ Are you breast-feeding? Yes/No

Do you have any concerns about your pregnancy that your therapist should be aware of?
_____
_____

Facial and Skin Analysis

Please tick any of the following concerns that applies to you:

☐ Dry	☐ Combination	☐ Thread veins
☐ Oily	☐ Acne	☐ High colour
☐ Fine lines & wrinkles	☐ Scarring	☐ Cellulite
☐ Sensitive	☐ Rosacea	☐ Aches & pains
☐ Pigmentation	☐ Blocked pores	☐ Lack of muscle tone
☐ Dull	☐ Dark circles	☐ Overweight

Please list any other concerns you may have that are not listed above:

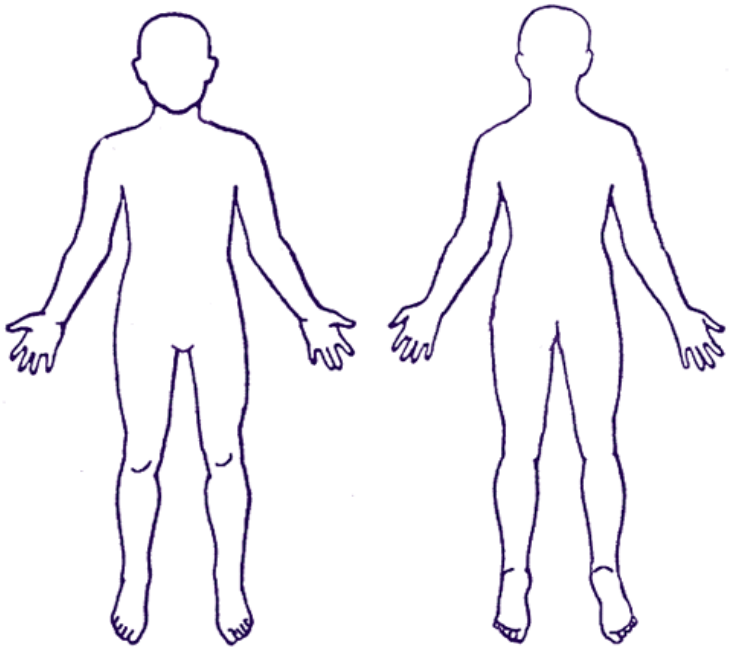
_____

Do you currently have a skincare routine? Yes/No
If yes, what is your routine?

_____

_____

Please mark below where you have any areas of concern and areas you want us to concentrate on.



Mailing List – Please tick the box to receive exclusive offers

I would like to receive special offers and updates from The Norfolk Mead Treatment Rooms ☐

Declaration

Please can you make sure all the information given above is correct, true and up to date. At the Norfolk Mead Hotel treatment rooms, we will not be held responsible for any consequences of being given false information or no information at all, which may affect specific treatments. All treatments are for general purposes and not intended for substitution of medical procedures.

Please note: We will never share your personal information with any 3rd parties and all information supplied will only be used for the purpose of your treatment, All personal information is only accessible to our Therapists and Reservation teams. You may view your personal file at any time via our Therapists.

Guest Signature: _____ Date: _____