Spa Consultation Form

GUEST NAME: _____ **GUEST TYPE:** *Resort | Marina | Local | External*

EMAIL: _____ **ROOM/SLIP NUMBER:** _____

TELEPHONE: _____ **DOB:** _____

COUNTRY & STATE/PROVINCE: _____ **SEX:** *Female | Male | Prefer Not To Answer*

CIRCLE TREATMENTS YOU'RE INTERESTED IN:
Facial | Massage | Body Treatment | Manicure/Pedicure | Haircare

PRESSURE: *Soft | Medium | Strong*

Have you received a massage before? Yes ☐ No ☐

When was your last massage? _____

Do you have any known allergies? Yes ☐ No ☐

If yes, what are they? _____

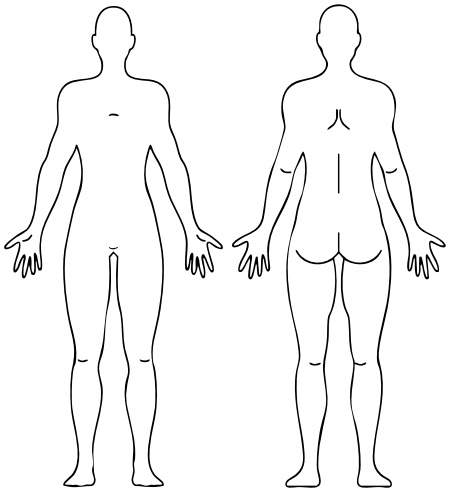
Are you pregnant? Yes ☐ No ☐ If yes, how many months?

MEDICAL INFORMATION:

Please check any conditions that apply to you:

- ☐ Diabetes
- ☐ Back/Neck Problems
- ☐ Varicose Veins
- ☐ Osteoporosis
- ☐ Epilepsy
- ☐ Carpel Tunnel Syndrome
- ☐ Fibromyalgia
- ☐ Headaches/Migraines
- ☐ Heart Condition
- ☐ Easy Bruising
- ☐ Open Sores/Wounds
- ☐ Contageous Skin Condition
- ☐ High/Low Blood Pressure
- ☐ Deep Vein Thrombosis/Blood Clots
- ☐ Arthritis/Joint Disorder
- ☐ Cancer
- ☐ TMJ
- ☐ Other

CIRCLE THE AREAS OF FOCUS | PLACE AN X ON AREAS TO AVOID



Clients under the age of 18 must be accompanied by a parent/ guardian during the treatment. Written consent must be provided by parent/ guardian for any client under the age of 18.

DECLARATION: I acknowledge that I have provided accurate and complete information regarding my health, allergies, medications, and recent treatments. I understand that spa and salon services are intended for relaxation and wellness purposes only and are not a substitute for medical care. I accept that results may vary and no guarantees are made. I release The Spa at Peter Island, its employees, and contractors from any liability for injury, allergic reaction, or adverse effects that may occur during or after the treatment, except in cases of proven negligence. I agree to follow the spa's cancellation and payment policies as communicated to me. By signing below, I consent to receive the agreed treatment and understand that I may stop the service at any time.

Signature: _____

Date: _____

Name(s) of Minor Child(ren) Engaging in the Activity:

_____

I am the parent or legal guardian of the minor(s) named above. I have the legal right to consent on their behalf and, by signing below, I hereby do consent to the terms and conditions of this Release of Liability.

Printed Name: _____

Signature: _____

Date: _____

The Spa at Peter Island

×××

FOR THERAPIST USE ONLY

First Visit

THERAPIST _____ DATE _____

TREATMENT _____ ROOM NUMBER _____

OIL/CREAM _____ DURATION _____

PRODUCTS RECOMMENDED _____ SCRUB/WRAP _____

_____ NOTES/ADD-ONS _____

Second Visit

THERAPIST _____ DATE _____

TREATMENT _____ ROOM NUMBER _____

OIL/CREAM _____ DURATION _____

PRODUCTS RECOMMENDED _____ SCRUB/WRAP _____

_____ NOTES/ADD-ONS _____

Third Visit

THERAPIST _____ DATE _____

TREATMENT _____ ROOM NUMBER _____

OIL/CREAM _____ DURATION _____

PRODUCTS RECOMMENDED _____ SCRUB/WRAP _____

_____ NOTES/ADD-ONS _____

Fourth Visit

THERAPIST _____ DATE _____

TREATMENT _____ ROOM NUMBER _____

OIL/CREAM _____ DURATION _____

PRODUCTS RECOMMENDED _____ SCRUB/WRAP _____

_____ NOTES/ADD-ONS _____

×××