Client Profile

Ganga Spa
relax, refresh, rejuvenate

Client Details

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

Forename:

Surname:

Address:

Postcode:

Telephone (home):

Telephone (mobile):

Email:

Date of Birth: ☐ or confirm you are 18 years of age

Client Signature:

Confidential Medical Details

What is your general state of health?

Do you suffer from any of the following Medical Conditions?

- ☐ Allergies
- ☐ Cancer
- ☐ Epilepsy
- ☐ Diabetes
- ☐ Heart Conditions
- ☐ High/Low Blood Pressure

Are you suffering from any of the following conditions?

- ☐ Back problems
- ☐ Hyperthyroid
- ☐ Claustrophobia
- ☐ Eczema
- ☐ Migrane Headaches
- ☐ Rheumatism
- ☐ IBS
- ☐ Constipation
- ☐ Menopause
- ☐ Depression
- ☐ Asthma
- ☐ Arthritis
- ☐ Psoriasis

Skin Types and Concerns

Face

- ☐ Normal
- ☐ Pigmentation
- ☐ High Colour
- ☐ Dry
- ☐ Congestion
- ☐ Sun Damage
- ☐ Combination
- ☐ Sensitivity
- ☐ Dark Circles / Puffiness
- ☐ Oilyness
- ☐ Acne
- ☐ Other
- ☐ Dullness
- ☐ Fine Lines

Body

- ☐ Dry Skin
- ☐ Aches and Pains
- ☐ Over / Under Weight
- ☐ Poor Circulation
- ☐ Cellulite
- ☐ Other

What is your main concern?

If there was one thing you could change about yourself what would it be?

How would you like to feel today after your treatment?

Client Signature:

I declare that to the best of my knowledge the information given is correct.

Lifestyle Questionnaire

Y	N	
☐	☐	Is your sleep disturbed?
☐	☐	Do you smoke?
☐	☐	Are you taking any medication?
☐	☐	Are you pregnant or breastfeeding?
☐	☐	Do you exercise regularly?
☐	☐	Have you had any surgery in the past 6 months?
☐	☐	Is there any history of family illness?

Date	Therapist	Treatment	Recommendations