BLOOM BEAUTY & WELLNESS SPA
4 BROMMAERT AVENUE CONSTANTIA CPT
PO BOX 441 CONSTANTIA 7848
bookings@bloombeauty.co.za
bookings : 083 642 2916 (WhatsApp/ SMS)
accounts : 083 452 2916 (WhatsApp/ SMS)
www.bloombeauty.co.za
www.facebook.com/bloombeautycpt

CLIENT INFORMATION & HEALTH HISTORY

All information provided below is kept fully confidential by our team & used only for the purposes of providing appropriate and suitable beauty therapy & wellness care

CONTACT INFO

NAME					
BIRTH DATE					
ADDRESS					
SUBURB					
CITY		POSTCODE			
CELL NO		May we send you promo info?		YES	NO
EMAIL					
REFERRED BY					

HEALTH INFORMATION

Is this your first professional massage / beauty therapy?		YES	NO
If no, how frequently do you receive a massage?			
If no, how frequently do you receive a mani- or pedicure?			
What other therapies have you tried? (detail below)			

Are you under a doctor or other health practitioner's care?		YES	NO
If yes, please give a brief description:			

Please check any of the conditions below which may apply to you:

☐	Headaches	☐	Asthma	☐	Smoking	☐	High Blood Pressure
☐	Phlebitis	☐	Varicose Veins	☐	Stroke	☐	Low Blood Pressure
☐	Pregnancy	☐	Bruise Easily	☐	Pace Maker	☐	Poor Circulation
☐	Arthritis	☐	Skin Conditions	☐	Diabetes	☐	Heart Disease
☐	Painful Menstruation	☐	Epilepsy	☐	Sinus Infection	☐	Heart Attack
☐	Alcohol Use	☐	Drug Use	☐	Insomnia	☐	Cancer
☐	Painful Joins / Bursitis	☐	Fybromyalgia	☐	Oedema	☐	Rash / Skin Irritation
☐	Open Wounds	☐	Nut Allergies	☐	Other Allergies	☐	Other

If Other or Other Allergies please detail	

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Please describe any surgeries, hospitalizations, accidents or injuries you have had, and any open or healing wounds:
Please list any medications you are currently taking: (specifically anti-inflammatory, pain killers, muscle relaxers, and blood thinners)
Describe the nature of the pain – is it local, does it radiate outward, is there a position of comfort, or restriction of movement?

When did the "problem" start?	
What has helped relieve the "problem"?	

What are your expectations for your session today?
Other health conditions or comments:

By signing this document, I, (please print your name)_____, understand that this is a confidential medical history and that all medical records and conversations with my therapist will remain private. Advice from the therapist is non-medical and does not replace seeing a doctor. I also understand that my therapist will only work within her scope of practice, that I have the right to ask my therapist not to massage any part of my body I am not comfortable having massaged, and that this massage is for the purposes of relaxation and the relief of stress and muscular tension. I give my consent for my therapist to treat me.

I also agree that by using the services of Bloom Beauty & Wellness on the premises, I do so fully at my own risk, and by entering the premises and using said services, I hereby indemnify the owners, their agents and therapists of all claims of loss or injury, howsoever arising

SIGNATURE		DATE	

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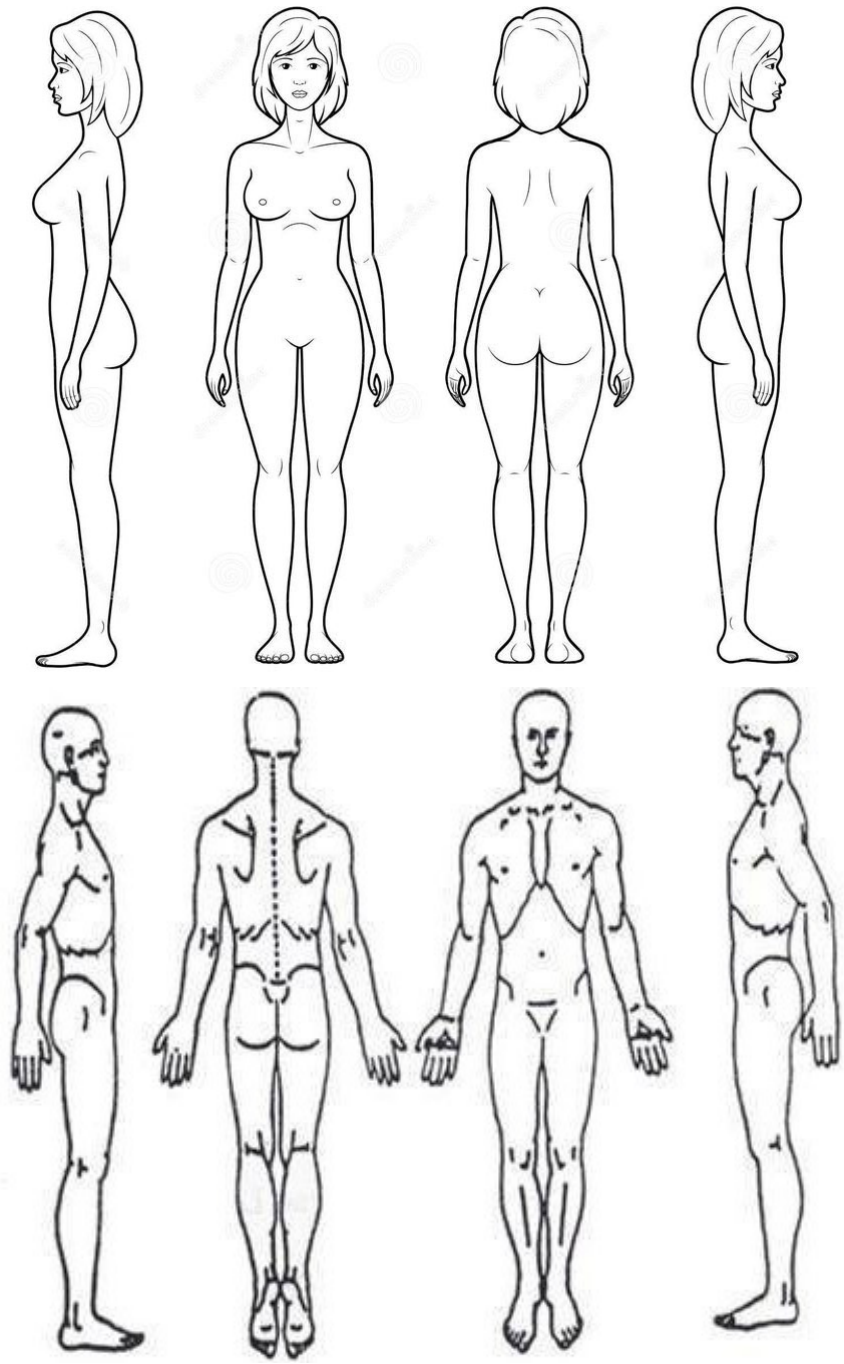
Preferred Pressure	Light	Medium	Deep	?

Please circle areas that you feel need extra work. CROSS OUT any areas you would like to be avoided.



SIGNATURE:	