your personal consultation

ESPA

Title _____ First Name _____ Family Name _____ D.O.B. _____ Female ☐ Male ☐

Email _____ Telephone _____

Address _____

Are you: ☐ A member? ☐ A hotel guest? ☐ A day spa guest? ☐ A spa/salon client? ☐ None of these apply

Medical information

If you have any health condition (whether or not listed below) we recommend that you proceed only with your doctor's approval.

- ☐ Heart conditions/Strokes
- ☐ Cancer/Chemotherapy
- ☐ High/Low blood pressure
- ☐ Diabetes (Type 1 or 2)
- ☐ Epilepsy
- ☐ Hepatitis
- ☐ Kidney/Liver disorders
- ☐ Thyroid problems
- ☐ Poor circulation
- ☐ Recent Operations including Laser Eye Surgery
- ☐ Pregnancy/IVF/ Breast feeding
- ☐ Depression/Anxiety
- ☐ Water retention/Oedema
- ☐ Claustrophobia
- ☐ Joint problems/ Hyper mobility
- ☐ Muscular pain
- ☐ Asthma
- ☐ Varicose veins/DVT
- ☐ Thrombosis
- ☐ Sclerotherapy
- ☐ Iodine/Shellfish sensitivities
- ☐ Food/Nut allergies
- ☐ Product allergies
- ☐ Skin sensitivity/Allergies
- ☐ Sunburn
- ☐ Hormonal imbalance
- ☐ Acne/Rosacea
- ☐ Psoriasis/Eczema
- ☐ Recent cosmetic surgery
- ☐ Botox/Restylane/ Fillers/Collagen
- ☐ Microdermabrasion Chemical peels
- ☐ Use of AHA's/Retinol Retin A/Roacutin
- ☐ Foot infections
- ☐ Contact lenses

Is there anything else you think we should know regarding your health that may affect or prevent you having treatment? _____

Are you taking any medication or homeopathic supplements? _____

Your Permission

I consent to the use of my personal data (including any sensitive personal data) by the treatment provider, for the purpose of my treatment and any future treatment. For more information about the privacy policy please refer to your treatment provider. I agree that any treatment is at my own risk without limiting or affecting my statutory rights. I agree that any dispute or claim that arises out of or is related to such treatment and/or spa services shall be subject to the law and exclusive jurisdiction of the courts of the country/region in which the relevant treatment/service took place.

Guest signature (1st visit) _____ Date _____

From time to time we, (and ESPA International (UK) Limited) would like to contact you with information on new products and promotions.
Please tick here if you wish to receive future mailings from ESPA International (UK) Limited ☐
Please tick here if you wish to receive future mailings from the treatment provider ☐

first visit

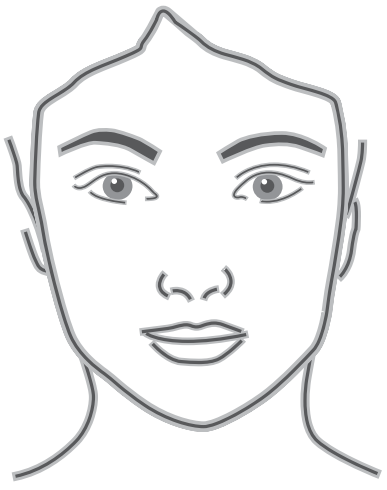
What are your main concerns?

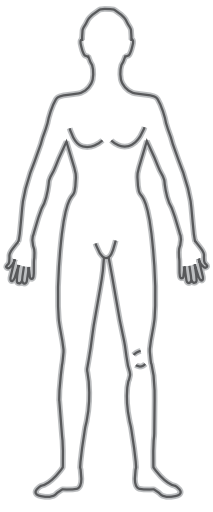
What results would you like to achieve?

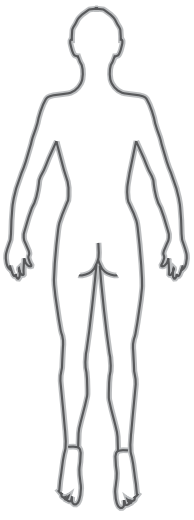
What is your current routine? Face:

Body:

Please highlight areas of need / concern with a cross on the diagrams below, stating the issue. For example dry skin / tension.







for therapist use only

Date: Therapist: Treatment: ☐ Face ☐ Body

Sensory test results:

Treatment notes:

Products recommended:

Skin Type: O Dry O Oily/Combination O Normal O Sensitive O Maturing

second visit

Please indicate any changes to the medical information already identified on your previous visit:

Please specify any changes to your main concerns?

Any medication changes? Yes / No Please specify:

Date: Signature:

for therapist use only

Therapist: Treatment: ☐ Face ☐ Body

Sensory test results:

Treatment notes:

Products recommended:

third visit

Please indicate any changes to the medical information already identified on your previous visit:

Please specify any changes to your main concerns?

Any medication changes? Yes / No Please specify:

Date: Signature:

for therapist use only

Therapist: Treatment: ☐ Face ☐ Body

Sensory test results:

Treatment notes:

Products recommended:

fourth visit

Please indicate any changes to the medical information already identified on your previous visit:

Please specify any changes to your main concerns?

Any medication changes? Yes / No Please specify:

Date: Signature:

for therapist use only

Therapist: Treatment: ☐ Face ☐ Body

Sensory test results:

Treatment notes:

Products recommended:

fifth visit

Please indicate any changes to the medical information already identified on your previous visit:

Please specify any changes to your main concerns?

Any medication changes? Yes / No Please specify:

Date: Signature:

for therapist use only

Therapist: Treatment:: ☐ Face ☐ Body

Sensory test results:

Treatment notes:

Products recommended:

sixth visit

Please indicate any changes to the medical information already identified on your previous visit:

Please specify any changes to your main concerns?

Any medication changes? Yes / No Please specify:

Date: Signature:

for therapist use only

Therapist: Treatment: ☐ Face ☐ Body

Sensory test results:

Treatment notes:

Products recommended:

seventh visit

Please indicate any changes to the medical information already identified on your previous visit:

Please specify any changes to your main concerns?

Any medication changes? Yes / No Please specify:

Date: Signature:

for therapist use only

Therapist: Treatment: ☐ Face ☐ Body

Sensory test results:

Treatment notes:

Products recommended: