



# Dalhousie Castle

HOTEL AND AQUEOUS SPA

## Contact Details

Date: ..... Address: ..... **Telephone Number**

Title: ..... Day: .....

Surname: ..... Evening: .....

First Name: ..... Mobile: .....

Date of Birth: DD/MM/YY ..... Postcode: ..... E-Mail: .....

By ticking this box, you agree to Dalhousie Castle Hotel and Aqueous Spa's Privacy Statement which can be found on our website.

The following information is required to ensure that we can provide you with the best and most appropriate treatment as well as for your safety and well-being. Some of the treatments we provide may be contra-indicated by certain medical conditions and therefore may require a doctor's letter of referral. Please fill this form in to the best of your knowledge and kindly remind us of any subsequent changes to your health and well-being.

## Medical History

To enable our therapist to carry out an efficient, safe and effective treatment please read and answer the following questions as appropriate. All information given is strictly confidential, if you have answered yes in any of the boxes, please give full details below.

### Do you suffer from any of the following?

Allergies/ Intolerance	YES <input type="checkbox"/> NO <input type="checkbox"/>	Are you pregnant or planning a pregnancy?	YES <input type="checkbox"/> NO <input type="checkbox"/>
Diabetes	YES <input type="checkbox"/> NO <input type="checkbox"/>	Are you breastfeeding?	YES <input type="checkbox"/> NO <input type="checkbox"/>
Thrombosis	YES <input type="checkbox"/> NO <input type="checkbox"/>	Have you experienced any gynaecological problems?	YES <input type="checkbox"/> NO <input type="checkbox"/>
High/Low blood pressure	YES <input type="checkbox"/> NO <input type="checkbox"/>	Are you on HRT or any other hormones?	YES <input type="checkbox"/> NO <input type="checkbox"/>
Asthma	YES <input type="checkbox"/> NO <input type="checkbox"/>	Are you on any medication or under medical supervision?	YES <input type="checkbox"/> NO <input type="checkbox"/>
Iodine (seaweed) allergy	YES <input type="checkbox"/> NO <input type="checkbox"/>	Have you had any major operations/accidents or illnesses in the last 5 years?	YES <input type="checkbox"/> NO <input type="checkbox"/>
Hepatitis A or B	YES <input type="checkbox"/> NO <input type="checkbox"/>	Have you ever used Roaccutane or Retin A?	YES <input type="checkbox"/> NO <input type="checkbox"/>
Kidney conditions	YES <input type="checkbox"/> NO <input type="checkbox"/>	Do you have any metal pins or plates in your body?	YES <input type="checkbox"/> NO <input type="checkbox"/>
Epilepsy	YES <input type="checkbox"/> NO <input type="checkbox"/>	Do you have any muscular or skeletal problems?	YES <input type="checkbox"/> NO <input type="checkbox"/>
Heart disease	YES <input type="checkbox"/> NO <input type="checkbox"/>	Have you suffered from any sports injuries?	YES <input type="checkbox"/> NO <input type="checkbox"/>
Pacemaker	YES <input type="checkbox"/> NO <input type="checkbox"/>	Have you had recent cosmetic surgery?	YES <input type="checkbox"/> NO <input type="checkbox"/>
Cold Sores	YES <input type="checkbox"/> NO <input type="checkbox"/>	Have you had any cosmetic enhancement procedures? (Botox, Restaulin, Collagen, Dermabrasion, AHA or Chemical peel, Liposuction etc within the last 4 weeks)?	YES <input type="checkbox"/> NO <input type="checkbox"/>
Thyroid	YES <input type="checkbox"/> NO <input type="checkbox"/>	Have you been prescribed any medication by your Doctor?	YES <input type="checkbox"/> NO <input type="checkbox"/>
Digestive problems	YES <input type="checkbox"/> NO <input type="checkbox"/>	If you have answered YES to any of the above please provide further details:	
Cancer - In the last 5 years	YES <input type="checkbox"/> NO <input type="checkbox"/>		
Circulatory conditions	YES <input type="checkbox"/> NO <input type="checkbox"/>		

Please give details if applicable:

### Client Declaration

I hereby declare that the information provided on this form is correct and I undertake to inform you of any changes to my medical status. If I have answered yes to any of the questions relating to my health, I have been informed of the risks from the identified indications and the therapist's decision to go ahead with the treatment is final. I understand what I have been told and want to go ahead with the treatment. I understand that Dalhousie Castle Hotel and Aqueous Spa does not accept any liability.

Signed Client: .....

Name: ..... Date: .....

### Therapist Declaration

I have referred to the treatment contra-indications provided in my training, product house supplier and Spa Beauty Treatment risk assessment and have given advice according to this.

Signed Therapist: .....

Name: .....

Date: .....