PRIVATE AND CONFIDENTIAL FOR SALON USE ONLY

This information is for the use of The Treatment Rooms Staff only and will not be sold on to any third parties

	…………..	**Have you ever suffered from any of the following conditions, if so please give details**	
TITLE	…………..		
SURNAME	…………. ………………………	DIABETES	**YES/NO**
FORENAME	…………. ………………………	EPILEPSY	**YES/NO**
DATE OF BIRTH	…………. ………………………	HEART PROBLEMS	**YES/NO**
ADDRESS	……………………………………	PACEMAKER / LEADS	**YES/NO**
	……………………………………	HIGH / LOW BLOOD PRESSURE(circle appropriate)	**YES/NO**
POSTCODE	…………. ………………………	RECENT OPERATION	**YES/NO**
OCCUPATION	…………. ………………………	RECENT SCAR TISSUE	**YES/NO**
HOME TEL:	…………. ………………………	METAL PLATES / PINS	**YES/NO**
MOBILE TEL:	…………. ………………………	THROMBOSIS / VARICOSE VEINS	**YES/NO**
EMAIL	……………………………………	ASTHMA	**YES/NO**
HOW DID YOU HERE ABOUT US?		ALLERGIES	**YES/NO**
GOOGLE	☐	PSORIASIS / EXCEMA	**YES/NO**
WEB SEARCH	☐	I.B.S	**YES/NO**
SALON SIGN	☐	JOINT OR MUSCULAR PROBLEMS	**YES/NO**
LEAFLET	☐	MUSCULAR PAIN	**YES/NO**
OUR WEBSITE	☐	NERVE DAMAGE	**YES/NO**
FIRWOOD WATERLOO RUGBY	☐	PREGNANCY - WITHIN 3 MONTHS	**YES/NO**
FIRWOOD BOOTLE CRICKET	☐	CANCER and or CHEMOTHERAPY	**YES/NO**
OTHER	☐	FACIAL DERMA-BRASION / LASER	**YES/NO**
RECOMMENDED BY A FRIEND	☐	FACIAL INJECTION e.g. BOTOX / FILLERS	**YES/NO**
By whom, we'd like to thank them		ARE YOU TAKING ANY MEDICATION	**YES/NO**
………………………………………………………………..		**DETAILS IF ANY** ………………………………………………	
		…………………………………………………………….	

COVID 19 DECLARATION

Have you had a temperature in the last 7 days prior to this appointment? **YES/NO**

Have you been in contact with someone who has had or suspected Covid 19 in the last 14 days? **YES/NO**

Have you shown symptoms of a fever, cough, loss of taste/smell or a rash in the last 7-14 days? **YES/NO**

COMPULSORY DISCLAIMER

I confirm and agree that any treatment is at my own risk other than in relation to any physical or mental harm i may suffer due to negligence and without limiting or affecting any statutory rights i may have. The therapist reserves the right to terminate any treatment if she feels the client's behaviour is undesirable or inappropriate or a risk to their safety and wellbeing. I agree that my treatment time may be reduced due to lateness and still be charged the full treatment price. I agree to paying an additional £5 charge for PPE provided during each appointment. I agree to paying a full charge for missed appointments without 24 hours minimum notice.

Client Signature…………………………..........................

Date………………………..

FREEGIFT OF £5 OFF 1ST TREATMENT* FOR YOUR FRIEND

* We would like to treat one of your friends or family members to a Free Gift of £5 Off their first treatment in our salon providing that they have been nominated by you and providing that they have **NEVER** been into The Treatment Rooms before as a client.

In order for your friend to benefit from this FANTASTIC FREE £5 OFF you must complete their contact details below.

FRIENDS NAME ……………………………………………………..

RELATIONSHIP ……………………………………………………..

MOBILE NUMBER ……………………………………………………..

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THERAPIST…………………………….**DATE INPUT**……………………………… …………………………

UNIQUE ID REF.................................

Client NAME...