INDEMNITY FORM

Spoil Yourself!

Name		**Room No.** (If applicable)	
Tel/Mobile			
E-Mail		**Date of Birth**	
ID/Passport Number			
Address			
How did you hear about us?			
Therapist's Name			

OFFICE USE

☐ Permanent Resident ☐ Weekend Visitor - SA Resident ☐ Foreign Tourist

INDEMNITY

I, ____ hereby indemnify Mint Wellness (Pty) Ltd, the spas and salons at The Bay Hotel, Camps Bay Retreat, The Farmhouse Hotel, Harbour House Hotel, Village & Life Ltd, the property owner, staff and management from any injury, disease, death, damage or loss I may experience, irrespective if caused by treatments or activities – internal or external.

I declare that I will participate in such activities of my own free will and have been informed about the nature of treatments given.

I have been informed that the slippers provided by the spas and salons are not recommended for outdoor use or at any pool areas.

I understand that the services received are not a substitute for medical care and any information provided by the aesthetician is for educational purposes only.

All the information mentioned on this form is correct and I cannot hold the therapist responsible for any defaults.

Client signature: ________________________________ ***Date:*** ________________________________

Therapist signature: ______________________________ ***Date:*** ________________________________

MINT WELLNESS (PTY) LTD - Registration Number: 1999/023334/07
Directors: EM Brink, J Lategan

CONSULTATION

Skin Type and Concerns:

☐ Normal	☐ Dry	☐ Oily	☐ Combination
☐ Acne	☐ Sensitive	☐ Extra Sensitive	☐ Sun Damage
☐ Lines/Wrinkles	☐ High Colour	☐ Pigmentation	☐ Dark Circles/Puffiness

Lifestyle:

What is your quality of sleep?	☐ Deep	☐ Light	☐ Disturbed	
What is your current status?	☐ Working	☐ Home-based	☐ Retired	
What hours do you work?	☐ Part-time	☐ Shift-work	☐ Full-time	☐ Home-based
How do you travel to work?	☐ Walk	☐ Public Transport	☐ Car	
How often do you exercise?	☐ Never	☐ Daily	☐ Weekly	
Do you smoke?	☐ No	☐ 1-20 per day	☐ 20+	
Do you wear contact lenses?	☐ Yes	☐ No		

Diet:

How would you describe your diet?	☐ Balanced	☐ Moderate	☐ On the run	☐ Poor
How many units do you drink per day?	☐ Water	☐ Fresh Juices	☐ Alcohol	☐ Coffee/Tea
Are you vegetarian?	☐ Yes	☐ No		

What is your current skin care routine? ______________________________

____

Body Concerns:

☐ Dry Skin	☐ Cellulite	☐ Poor Circulation	☐ Aches/Pains	☐ Varicose Veins
☐ Overweight	☐ Other: ______________________________			

What is your current skin care routine? ______________________________

____

Do you have any of the following conditions or make use of:

☐ Allergies	☐ Eczema	☐ Rheumatism	☐ Asthma	☐ High/Low Blood Pressure
☐ Heart Condition	☐ Cancer	☐ Hyperthyroid	☐ Epilepsy	☐ Iodine (Seaweed/Shellfish)
☐ Pacemaker	☐ IBS	☐ Constipation	☐ Psoriasis	☐ Claustrophobia
☐ Dilated Capillaries	☐ Arthritis	☐ Back Problems	☐ Diabetes	☐ Artificial Implants
☐ Birth Control	☐ Contact Lenses	☐ Metal Plates/Pins		

☐ Other, please specify (also specify allergies) ______________________________

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Are you going through any of the following?

☐ Depression	☐ Menopause	☐ PMT	☐ Headaches/Migraines
☐ Pregnancy	☐ Breastfeeding	Other (please list) ______________________________	

Medical History

Are you on medication or under medical supervision? Y/N ______________________________

Is there history of any family illness? Y/N ______________________________

Have you had any recent surgery, accidents or injuries? Y/N ______________________________

TV0205 30/10/2014