mint wellness
spoil yourself

CONSULTATION FORM
2023

Name _____ **Date** _____

Tel no. _____ **E-mail** _____

INDEMNITY

I, _____ the undersigned, hereby indemnify and hold harmless Mint Wellness (Pty) Ltd, the Spa and/or Salons and/or Health Facilities at The Bay Hotel, Camps Bay Retreat, Pezula Hotel, Harbour House Hotel, The Farmhouse Hotel and/or any property owned and/or managed by or on behalf of Village N Life (Pty) Ltd, the Property Owner, Staff and Management from any injury, disease, death, damage or loss I may experience.

I declare that any participation in activities and/or treatments at any of the aforementioned facilities are at my own risk.

I understand that the services received are not a substitute for medical care and any information and/or advice given by the aesthetician/ beauty therapist is for educational purposes only.

All the information supplied on this form is correct and I agree that I cannot hold the aesthetician/ beauty therapist responsible for any loss, damage and/or injury or illness howsoever caused.

Client signature: _____

Mint Wellness to complete:

Overnight Guest YES / NO **If yes, add room number** _____

Day Visitor YES / NO **VNL Leisure Club member** YES / NO

Therapist's Name _____ **Therapist Signature** _____

Skin Type and Concerns:

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

What is your current skin care routine? _____

Body Concerns:

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

☐ Other: _____

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

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

☐ Other, please specify (also specify allergies) _____

Are you going through any of the following?

☐ Depression ☐ Pregnancy ☐ Menopause ☐ Breastfeeding ☐ PMT ☐ Headaches/Migraines

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 _____