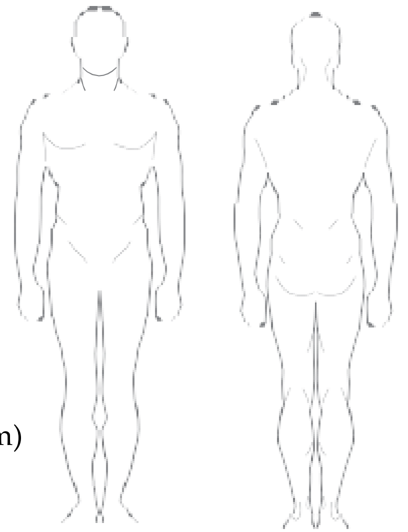
ACKNOWLEDGEMENT

Guest Name____

Contact No ____

Due to the **COVID-19** pandemic, we are taking extra precautions with the intake of each guest. Please advise your therapist immediately if you have any of the following symptoms so we may continue to do our best to stop the spread

- fever
- fatigue
- dry cough
- difficulty breathing
- sore throat
- loss of smell or taste



How would you like to feel after your visit today?

☐ Relaxed ☐ Energized ☐ De-stressed ☐ Balanced

Are there any specific areas you would like to focus on today? (Please circle on diagram)

Do you experience any of the following?

FACE

☐ Acne breakout ☐ Age spots ☐ Broken capillaries ☐ Burns ☐ Dark circles
☐ Decreased elasticity ☐ Dehydration ☐ Dryness ☐ Fine lines/Wrinkles ☐ Oiliness
☐ Pigmentation ☐ Product allergies ☐ Puffy eyes ☐ Rosacea ☐ Scarring
☐ Sensitivity ☐ Sun damage ☐ Fillers

Have you recently undergone any intensive facial treatments such as micro-dermabrasion, botox, laser or other?
Yes / No

Have you used any Retinol A products within the last 72 hours? ....

BODY

☐ Arthritis ☐ Bruise easily ☐ Cellulite ☐ Difficulty relaxing
☐ Dry skin ☐ Fluid retention ☐ Insomnia ☐ Lethargy
☐ Muscular atrophy ☐ Muscular pain/Cramps ☐ Neck trauma ☐ Numbness/Tingling
☐ Planter warts ☐ Poor circulation ☐ Sensitivity to heat ☐ Sluggish digestion
☐ Skin conditions/Sensitivity

ACKNOWLEDGEMENT

MEDICAL HISTORY

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

☐ Allergies (nuts, etc) ☐ Anxiety ☐ Asthma ☐ Blood pressure (high/low)
☐ Breast feeding ☐ Broken bones ☐ Cancer/Related treatment
☐ Claustrophobia ☐ Depression ☐ Diabetes ☐ Dizziness
☐ Eczema ☐ Epilepsy ☐ Heart conditions ☐ Hormonal imbalance
☐ Iodine sensitivities ☐ Joint problem ☐ Pregnancy (1st trimester / 2nd trimester / 3rd trimester)
☐ Psoriasis ☐ Recent operations/Surgeries ☐ Renal/Liver disorders ☐ Spinal disk injury
☐ Sprains or strains ☐ Thyroid Problem

If you answered yes to any of the conditions above please specify ....

....

Are you taking any medicine or supplements? ....

....

I acknowledge that I am at least 18 years of age and that the treatments provided at Willow Stream Spa at a Fairmont Hotel are not intended as a diagnosis and do not replace medical treatment. Should I be having a cupping massage I am aware that it may create bruising, if it is uncomfortable I will advise the RMT to discontinue this style of treatment. I further acknowledge that the information provided in this form is true, accurate and complete and that certain treatments may be refused to me on the basis of the information provided herein.

Signed .... Date ....

☐ YES, I would like to receive exclusive offers & communications from this Spa. (To view our privacy and opt-out policies please visit www.fairmont.com and select the privacy icon at bottom of the page.)

E-mail ....

FOR OFFICE USE ONLY:
Therapist has been advised by guest that the information provided in this form is true, accurate and complete.
(Therapist must complete the chart below.)

	Name of Therapist	**Treatment(s) Provided**	**Date**	**Therapist's Signature**
1.				
2.				