Name ______________________ Birthdate ______________________

Email ______________________ Mobile ______________________

Address ______________________ Occupation ______________________

Would you agree to receive txt reminders of appointments a day before? YES NO
Would you agree to be added to a database that emails you any changes or updates? YES NO

Please tick the boxes that indicate conditions that may be affecting your health

Allergies	☐	Low / High Blood Pressure	☐	Easy Bruising	☐
Asthma	☐	Chronic Pain	☐	Sensitive Skin	☐
Arthritis / Gout	☐	Headaches / Migraines	☐	OOS / RSI	☐
Cancer	☐	Viral / Fungal Infection	☐	Dizziness	☐
Diabetes	☐	Hepatitis A/B/C or HIV	☐	Numbness / Tingling	☐
Heart Attack / Condition	☐	Varicose Veins	☐	Fatigue / Exhaustion	☐
Stroke	☐	Thrombosis / Clots	☐	Fluid Retention	☐
Epilepsy	☐	Injuries / Sprain / Strain	☐	Swelling / Inflammation	☐
Psoriasis / Eczema	☐	Open Wounds / Rashes	☐	Are you pregnant	☐

Covid-19 Health Declaration

☐ I do not have COVID-19 nor am I awaiting the results from being tested for COVID-19

☐ I do not have any symptoms associated with COVID-19
(fever, cough, sore throat, shortness of breath, sneezing/runny nose or loss of sense of smell)

☐ I have not been in contact with any known or suspected cases of COVID-19 in the past 14 days

☐ I have not returned or been in contact with anyone who has returned from overseas in the past 14 days

☐ I have not been in an MIQ facility nor been in contact with someone who has been or works in MIQ, border or port areas.

☐ I hereby give permission for Beauty at Heart to forward my contact details to the Ministry of Health or local DHB if the business has been exposed to a possible case of Covid-19.

Have you had any recent injuries or surgeries that might be relevant to your treatment? ☐

Do you wear contact lenses, hearing aids, or have surgical implants? ☐

Are you taking any medication? ☐

Are you currently receiving treatment from an osteopath, physiotherapist, chiropractor or other physician? ☐

What are your physical activities / hobbies?

____

____

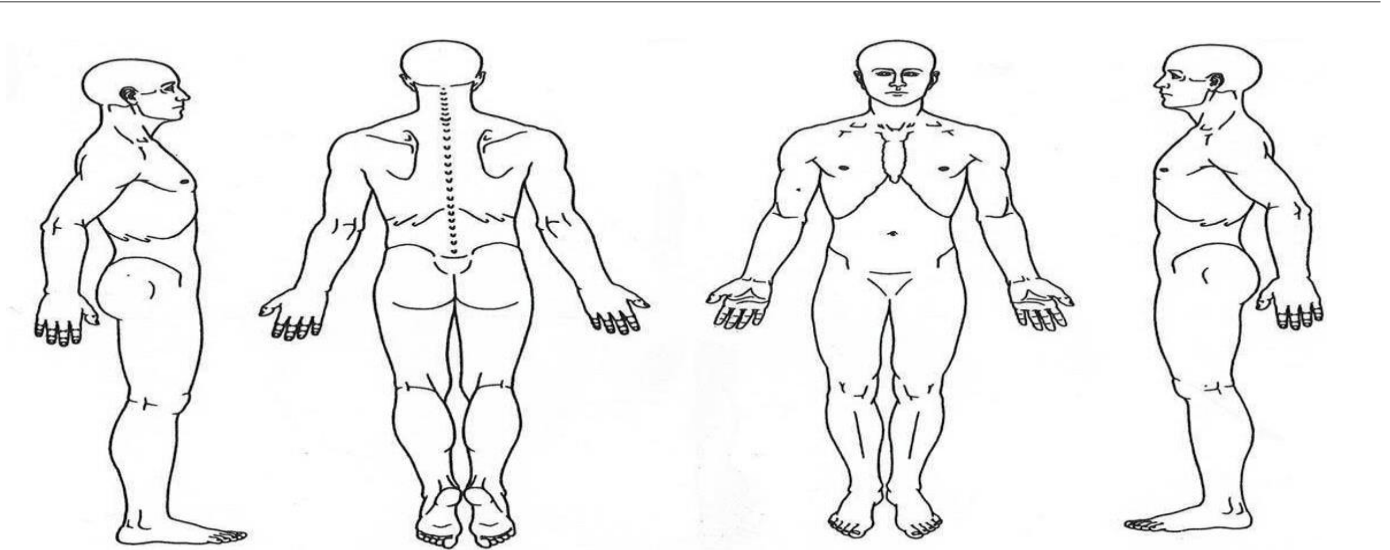
What would you like to achieve with massage? (tension release, relaxation, etc) What Massage pressure do you prefer?

____

Where are you currently experiencing discomfort, pain, muscle tension, aches? Please indicate these areas on the picture, and your therapist will discuss it with you.

____

____



☐ I understand that I should consult my physician if I have medical conditions that may become aggravated or if I may have severe ongoing effects from my massage or beauty therapy treatment.

☐ I am aware that I might experience mild discomfort, headaches, or tiredness after massage. This is a normal response after massage: post massage suggestions are to increase water intake and avoid strenuous exercise for 12 hours.

☐ I will endeavor to inform Beauty at Heart of any cancellations at least 24 hours prior to the appointment to avoid incurring a late cancellation fee.

☐ I certify that I have read and completed this form to the best of my knowledge and give consent to proceed with a consultation and massage and/or beauty therapy treatment.

☐ Please address any concerns or complaints to Beauty at Heart, or if not resolved, to the HEALTH AND DISABILITIES COMMISSION: PO Box 1791 Auckland.

Client Signature: ______________________________ Date : ______________