



Please take a moment and fill this out completely.

Name of Hotel _____ Room # _____

Name: _____

Country of Residence: _____

Email: _____ Contact No: _____

Do you suffer from any of the following? Diabetes -
Epilepsy - Asthma - Fainting Low Blood Pressure – High
Blood Pressure - Skin diseases/disorders - Phobias -
Muscles aches - Digestion - Kidneys - Liver - Heart - Lungs
- Skin - if so please give details. _____

Do you suffer from allergies from the following? Food -
Products - Medication - Iodine - Essential Oils - Material -
Heat if so, please give details.

Have you had an operation or an accident within the last
year or a past injury you still suffer from? If so, please give
details.

Which Pressure do you prefer ?

Deep Medium Light

Women only

Menstruations? *Yes* *No*

Are you pregnant ? *Yes* *No*

Trying to become pregnant ? *Yes* *No*

If not understood please feel free to ask the receptionist.
The spa cannot be held responsible for the aggravation of
any existing condition, as a result of treatment.

Signature: _____