Spa Client Intake Form

Confidential Client Information

pabau

¡ Please complete this form in full before your appointment. All information is kept strictly confidential and used solely to ensure your safety and deliver the best possible treatment experience.

Personal Information

Please provide your contact details so we can reach you regarding your appointments.

Full Name *

Date of Birth (DD/MM/YYYY) *

Phone Number *

Email Address *

Home Address

Gender

◯ Female ◯ Male ◯ Non-binary ◯ Prefer not to say

How did you hear about us?

Emergency Contact

In case of an emergency during your visit.

Emergency Contact Name *

Relationship to You *

Emergency Contact Phone Number *

Medical History

This information helps us identify any contraindications and tailor your treatment safely.

Do you currently have or have you ever been diagnosed with any of the following? *

☐ Heart disease ☐ High or low blood pressure ☐ Diabetes ☐ Epilepsy ☐ Cancer ☐ Blood clotting disorders

☐ Autoimmune conditions ☐ Thyroid disorder ☐ Asthma ☐ Hepatitis ☐ HIV/AIDS ☐ None of the above

Are you currently pregnant or breastfeeding? *

◯ Yes ◯ No ◯ Not applicable

Please list any medications or supplements you are currently taking:

Please list any known allergies (e.g. latex, fragrances, essential oils, nuts, plasters): *

Have you had any surgical procedures in the last 12 months? *

◯ Yes ◯ No

If yes, please provide details:

Skin Type & Concerns

Help us understand your skin so we can recommend the most suitable treatments.

How would you describe your skin type? *

◯ Normal ◯ Dry ◯ Oily ◯ Combination ◯ Sensitive ◯ Unsure

Do you experience any of the following skin concerns?

☐ Acne or breakouts ☐ Rosacea ☐ Eczema or psoriasis ☐ Hyperpigmentation ☐ Fine lines or wrinkles ☐ Sun damage
☐ Scarring ☐ Dullness or uneven texture ☐ Excessive dryness ☐ Sensitivity or redness ☐ None

Have you used retinoids or chemical peels in the last 4 weeks? *

◯ Yes ◯ No

Do you currently use sunscreen daily?

◯ Yes, SPF 30+ ◯ Yes, below SPF 30 ◯ Occasionally ◯ No

Treatment Preferences & Goals

Tell us what you hope to achieve so we can personalise your experience.

Which treatments are you interested in? (Select all that apply) *

☐ Facial treatments ☐ Body wraps or scrubs ☐ Massage therapy ☐ Manicure / Pedicure ☐ Waxing or hair removal
☐ Laser treatments ☐ Chemical peels ☐ Microdermabrasion ☐ LED light therapy ☐ Other

What are your main goals for today's visit?

Pressure preference (for massage services):

◯ Light ◯ Medium ◯ Firm ◯ No preference

Lifestyle Questions

These questions help us provide holistic recommendations.

How much water do you drink daily?

◯ Less than 1 litre ◯ 1-2 litres ◯ More than 2 litres

Do you smoke?

◯ Yes ◯ No ◯ Occasionally

How often are you exposed to direct sunlight?

◯ Rarely ◯ A few times a week ◯ Daily

How would you rate your stress levels?

◯ Low ◯ Moderate ◯ High

Please describe your current skincare routine (products used, frequency):

Consent & Declaration

¡ By signing below, you confirm that the information provided is accurate and complete to the best of your knowledge. You understand that withholding or providing inaccurate information may affect the safety and outcome of your treatment.

- [ ] I confirm that the information provided above is true and accurate to the best of my knowledge.
- [ ] I consent to the spa storing my personal and medical data securely in accordance with GDPR and applicable data protection regulations.
- [ ] I understand that I should inform my therapist of any changes to my health or medication before future treatments.

Client Signature

Print Name: _____ Date: ___/___/_____