**Full Name** **Date of Birth**

**Address Home Telephone Number** **Mobile Number**

**Email**

**Emergency Contact Number**

**Health Questionnaire – Do you have or have you had any of the following in the last 12 months?**

Asthma/Breathing Problems

Allergies

Eczema/Psoriasis/Dermatitis

Claustrophobia

Low Blood Pressure

High Blood Pressure

Heart Condition

Stroke

Blood Conditions

Diabetes

IBS

Nervous System Disfunction

Kidney/Liver Ailments

Fractures/Broken Bones

Metal Implants

Osteoporosis/Arthritis

Varicose Veins/Thrombosis

Epilepsy

Thyroid Condition

Undiagnosed Pain

Back Problems/Recent Injury

Pregnancy/Breast Feeding

Herpes Simplex/Impetigo

Major Illness (Cancer)

Headaches/Migraines

Covid-19

Surgery in the last 3-months

Botox/Fillers

Perforated Ears Drums

Infection or inflammation of the ear

Grommets, drains or ventilation tubes

Medication

**Further information**

I confirm that the information provided is accurate at the time of consultation on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. I will inform The Garden Retreat of any changes to my health or medication.

**Signed**

*The Garden Retreat uses the information to check for any contra-indications. If necessary the treatment may need to be adapted or changed to suit the persons needs.*

*Before and after photographs may be taken for certain treatments. All information is confidential and not shared with an outside company.*

**Skincare Questionnaire (Please circle)**

**How would you describe your skin?**

Normal

Dry

Dehydrated

Oily

Combination

Sensitive

Sun Damaged

Pigmented

Acne Prone

Other

**Would you like to improve the appearance of any of the following?**

Dark Circles

Puffy Eyes

Lines/Wrinkles

Spots/Pimples/Acne

Comedones (Blackheads)/Milia (Whiteheads)

Open Pores

Pigmentation

Scarring

Dullness

Redness

Rosacea

Dry/Flaky Skin

**What products do you use at home?**

Soap

Face Wipes

Facial Wash

Cleanser

Toner

Exfoliator

Mask

Day Cream

Night Cream

Serum

Eye Cream

SPF

Retinol

Supplements