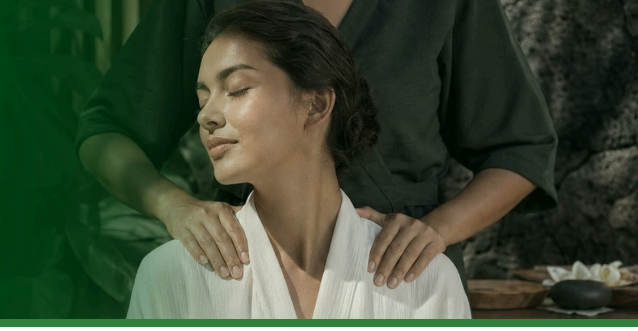
ORIENTAL SPA

CLIENT CONSULTATION FORM

MASSAGE · YOUR WELLNESS. OUR CARE.



Branch ☐ Plattekloof ☐ Brackenfell Date ____ / ____ / ____ (DD / MM / YYYY) Treatment booked _____

1 PERSONAL DETAILS

Full name _____

Date of birth ____ / ____ / ____ (DD / MM / YYYY) Age _____ ☐ Female ☐ Male ☐ Other

Mobile number + ____ (country code) _____ Email address _____

Address _____

Emergency contact — name _____ Number + ____ (country code) _____

2 HEALTH & MEDICAL HISTORY

Do you have, or have you had, any of the following? (tick all that apply)

Is this your first visit to Oriental Spa? ☐ Yes ☐ No

- ☐ Allergies — specify _____
- ☐ Diabetes
- ☐ Blood clots / thrombosis
- ☐ Recent surgery — specify _____
- ☐ Osteoporosis
- ☐ Skin conditions (e.g. eczema, psoriasis)
- ☐ Breastfeeding
- ☐ Asthma
- ☐ High / low blood pressure
- ☐ Varicose veins
- ☐ Joint problems
- ☐ Muscle / back problems
- ☐ Respiratory problems
- ☐ Menstrual conditions
- ☐ Epilepsy
- ☐ Heart condition / pacemaker
- ☐ Cancer — specify _____
- ☐ Arthritis
- ☐ Nerve damage
- ☐ Pregnancy — weeks _____
- ☐ Other — specify _____

If you ticked any of the above, please give details _____

3 MEDICATION

Are you currently taking any medication? ☐ No ☐ Yes Please specify _____

Have you taken any painkillers or medication today? ☐ No ☐ Yes Please specify _____

4 LIFESTYLE & WELLNESS

What is your main occupation? ☐ Desk / computer work ☐ Physical activities ☐ Travel ☐ Other _____

Have you had a massage before? ☐ No ☐ Yes When was your last massage? _____

5 BODY CONCERNS

- ☐ Muscle tension
- ☐ Poor circulation
- ☐ Aches / pains
- ☐ Swelling (e.g. legs / feet)
- ☐ Dry skin
- ☐ Stress
- ☐ Cellulite
- ☐ Other _____

6 MASSAGE PREFERENCES

What type of massage would you prefer today? (you can tick more than one)

- ☐ Oil / Swedish
- ☐ Deep tissue
- ☐ Aromatherapy
- ☐ Thai & oil (mixed)
- ☐ Back, neck & shoulder
- ☐ Hot stone
- ☐ Thai foot reflexology
- ☐ Sports / leg recovery
- ☐ Japanese shiatsu
- ☐ Chinese tapping
- ☐ Other _____

Pressure you prefer:

Light	Medium	Firm	Deep
Gentle, relaxing touch	Balanced pressure	Deeper, for tension relief	Stronger, for muscle knots
☐	☐	☐	☐

7 FOCUS AREAS *tick all that apply*

- ☐ Full body
- ☐ Back, neck & shoulders
- ☐ Legs
- ☐ Arms
- ☐ Hands & feet
- ☐ Scalp / head
- ☐ Other _____
- ☐ Areas to avoid _____

8 WHAT WOULD YOU LIKE TO ACHIEVE TODAY?

- ☐ Relaxation
- ☐ Stress relief
- ☐ Pain relief
- ☐ Improve circulation
- ☐ Better sleep
- ☐ Muscle recovery
- ☐ Other _____

9 CONSENT & AGREEMENT

- ☐ I have provided accurate information about my health, medical history and preferences. I understand that it is my responsibility to inform my therapist of any changes to the above information. I give my consent for the treatment to be carried out by the therapist at Oriental Spa.
- ☐ I understand the treatment may be adjusted or declined if it is not safe for me, and that spa treatments are for relaxation and wellbeing — not a substitute for medical care.
- ☐ **My health information:** I consent to Oriental Spa keeping the health information on this form so therapists at both branches can treat me safely.
- ☐ **Offers and news** by email or WhatsApp (optional — you can say no and still be treated).

Your privacy. Oriental Spa (Pty) Ltd collects this information to treat you safely. Only our reception team and therapists can see it, through our secure booking system, and every time someone opens your record it is logged. We do not sell or share it. We keep it for five years after your last visit, then delete it. You can ask to see or correct it at the branch email below. Should you wish to have your records deleted, please contact Oriental Spa Management: Jasmin Tshangana at jasmin@orientalspa.co.za.

Client signature _____ Date ____ / ____ / _____ (DD / MM / YYYY)

Therapist signature _____ Date ____ / ____ / _____ (DD / MM / YYYY)

If the client is under 18: Parent / guardian name _____ Relationship _____ Signature _____

OFFICE USE

Client ID (PC-/BC-) _____ Consent ref (PCF-/BCF-) _____ Captured on dashboard by _____