CHAMONIX
SPA & SALON

# LIFESTYLE CONSULTATION FORM

**Title:** Mr. | Mrs. | Ms. | Dr **First Name:** _____ **Last Name:** _____

**Room Number:** _____

*The information below will help your therapist customize your treatment and will be kept strictly confidential.*

**1. How are you feeling right now? Please rate your level of stress from 1 – 5.**

Relaxed 1 2 3 4 5 Stressed

**2. What would you like to achieve from your spa experience?**

☐ Relaxation ☐ Energizing ☐ Relieve Tension ☐ Ease Aches & Pain ☐ De-stress

**3. Which treatment pressure do you prefer?**

☐ Light ☐ Medium ☐ Deep

**4. Are there any areas you would like your therapist to concentrate on or avoid?**

**Concentrate on** ☐ Back ☐ Neck & Shoulder ☐ Legs ☐ Feet ☐ Arms

**Avoid** ☐ Back ☐ Neck & Shoulder ☐ Legs ☐ Feet ☐ Arms

**5. Your current lifestyle?** *(Please indicate ✓ for Yes or ✗ for No)*

☐ Healthy Eating ☐ Drink enough water? *Glasses per day* ☐ Sleep well? *Hours per night*

☐ Exercise regularly? *Hours per week* ☐ Consume alcohol? *Units per day*

☐ Smoke? *Units per day* ☐ Consume caffeinated drinks? *Glasses per day*

**6. Are you allergic or sensitive to any of the following?**

☐ Food ☐ Medication ☐ Iodine ☐ Heat ☐ Essential Oils

☐ Nuts ☐ Beeswax ☐ Others, please specify _____

**7. Have you had an operation or accident within the last year or any serious injury/condition in your lifetime?**

☐ Yes ☐ No *If yes, please give details including the presence of metal pins or plates* _____

**8. Are you suffering from any of the following?**

☐ Diabetes ☐ Epilepsy ☐ Asthma ☐ Heart Problems ☐ Kidneys/Liver Problems ☐ H/L Blood Pressure

☐ Skin Allergy ☐ Stress ☐ Arthritis ☐ Muscles Aches ☐ Digestive Problems ☐ Varicose Veins

☐ Spinal Problems ☐ Anxiety/Depression ☐ High Cholesterol ☐ Migraine/Headaches ☐ Other _____

**9. Are you pregnant or trying to become pregnant?**

☐ Yes ☐ No *If yes, how many months?*

☐ *I have read the above note which represents a complete and true account of my medical history. I have been advised of safety precautions and general advice on use of these spa facilities. I accept full liability for my decision to enter the spa and participate in spa services and facilities and will not claim or demand for any responsibility from the Chamonix Casino Hotel or their employees should I experience any adverse reaction, loss or damage to myself or my property due to any treatment or facility associated with Chamonix Casino Hotel. Data collected will be stored centrally by Chamonix Casino Hotel processed in accordance with our data privacy policy, is subject to confidentiality and only used to help us serve you better.*

**I understand that Chamonix Casino Hotel may collect and process my health and medical information ("Special Category Data") to provide the spa and wellness services, and I agree to such processing of my Special Category Data in accordance with the data privacy policy.**

**Signature** _____ **Date** _____

CHAMONIX
SPA & SALON

# WELLNESS PROFILE

*To be completed by spa therapists*

Therapist: _____ Date: _____ Time: _____

Treatment:

Remarks:

Treatment Recommendation:

Product Recommendation:

Therapist: _____ Date: _____ Time: _____

Treatment:

Remarks:

Treatment Recommendation:

Product Recommendation:

Therapist: _____ Date: _____ Time: _____

Treatment:

Remarks:

Treatment Recommendation:

Product Recommendation:

Therapist: _____ Date: _____ Time: _____

Treatment:

Remarks:

Treatment Recommendation:

Product Recommendation:

Therapist: _____ Date: _____ Time: _____

Treatment:

Remarks:

Treatment Recommendation:

Product Recommendation:

*The information gained from the consultation form and your spa experience will be kept strictly confidential.*