HEALTH & BEAUTY REGISTRATION

Welcome to Virgin Active. We ask all of our new clients to fill in the questions below, so we are aware of any pre-existing medical conditions before you receive any treatments.

We will also ask you questions about your lifestyle to assess your spa needs more accurately.

1. PERSONAL INFORMATION

DATE: _____

FIRST NAME: _____

SURNAME: _____

ADDRESS: _____

_____

CITY: _____

COUNTY: _____

POST CODE: _____

CONTACT NO: _____

EMAIL: _____

DOB: _____

GENDER: _____

MEMBER: ☐ **NON-MEMBER:** ☐

MEMBER NO: _____

NAME OF CONTACT IN CASE OF EMERGENCY: _____

PHONE NUMBER OF CONTACT IN THE EVENT OF AN EMERGENCY: _____

NAME OF GP: _____ **PHONE NUMBER OF GP:** _____

2. YOUR PERSONAL DATA

We take your privacy seriously. This section explains the ways in which we may use the information you have provided on this questionnaire which may relate to your physical health or condition. If you have any requests concerning your personal information, please contact reception (or your home club, if appropriate).

We reserve the right to retain copies of this form and the information contained in it (including relating to your physical wellbeing) for a reasonable period of time, even if we refuse an application by you for treatment (or membership where appropriate), if your course of treatment (or membership, if appropriate) is terminated for any reason or if, for any reason, we refuse you entry or ask you to leave our premises following your entry with a guest pass. This includes questions relating to your physical wellbeing as indicated on this form which you are required to complete as a condition of use of any of our facilities.

Please note that any information held by us relating to your physical status shall be held in the strictest confidence and not divulged to third parties or be used by us for marketing purposes.

3. YOUR PERMISSION

I hereby consent to the use of my personal data (including any sensitive personal data) for the purpose of my treatment and any future treatment and confirm that any treatment is at my own risk without limiting or affecting any statutory rights I may have. ☐

I agree that any dispute or claim that arises out of or is related to such treatment and/or spa services shall be subject to the law and the exclusive jurisdiction of the courts of the country/region in which the relevant treatment/service took place. Personal data will be held and used by the spa, salon or store providing the treatment and by Virgin Active. ☐

4. HEALTH & BEAUTY INFORMATION

From time to time we, the treatment provider, would like to contact you with information on new products and promotions.

Please tick here if you do not wish to receive future mailings. ☐

HEALTH & BEAUTY REGISTRATION

5. MEDICAL PROFILE

We take the safety of all our clients seriously so if you tick any of the questions below, we may request approval from your GP before proceeding with any treatments.

- ☐ HEART CONDITIONS/STROKES
- ☐ DIABETES (TYPE 1 OR 2)
- ☐ KIDNEY/LIVER DISORDERS
- ☐ JOINT PROBLEMS/HYPER MOBILITY
- ☐ VARICOSE VEINS/DVT
- ☐ PRODUCT ALLERGIES
- ☐ MIGRAINES
- ☐ COLD SORES
- ☐ CONTACT LENSES
- ☐ CANCER/CHEMOTHERAPY
- ☐ EPILEPSY
- ☐ THYROID PROBLEMS
- ☐ MUSCULAR PAIN
- ☐ THROMBOSIS
- ☐ SKIN SENSITIVITY/ALLERGIES
- ☐ ACNE/ROSACEA
- ☐ RECENT COSMETIC SURGERY
- ☐ RECENT OPERATIONS (INCL. LASER EYE SURGERY)
- ☐ HIGH/LOW BLOOD PRESSURE
- ☐ HEPATITIS/HIV
- ☐ PREGNANCY/ BREAST FEEDING
- ☐ ASTHMA
- ☐ FOOD/NUT ALLERGIES
- ☐ HORMONAL IMBALANCE
- ☐ PSORIASIS/ECZEMA
- ☐ BOTOX/RESTYLANE/FILLERS/COLLAGEN

ARE YOU ON ANY MEDICATION? YES: ☐ NO: ☐ IF YES, PLEASE GIVE DETAILS: _____

PLEASE GIVE ANY FURTHER DETAILS TO ANY YES ANSWERS ABOVE: _____

6. GENERAL HEALTH

DO YOU SMOKE?	YES: ☐	NO: ☐	IF YES, HOW MANY CIGARETTES PER DAY? _____
DO YOU DRINK ALCOHOL?	YES: ☐	NO: ☐	IF YES, HOW MANY UNITS PER WEEK? _____
DO YOU DRINK WATER DAILY?	YES: ☐	NO: ☐	IF YES, WHAT'S YOUR USUAL DAILY CONSUMPTION? _____
DO YOU HAVE A BALANCED DIET?	YES: ☐	NO: ☐	HOW OFTEN DO YOU EAT '5 A DAY' PER WEEK? _____
DO YOU GET ADEQUATE SLEEP?	YES: ☐	NO: ☐	HOW MANY HOURS PER NIGHT ON AVERAGE? _____
DO YOU SUFFER STRESS/TENSION?	YES: ☐	NO: ☐	IF YES, WHAT'S THE MAIN SOURCE? _____
DO YOU EXERCISE REGULARLY?	YES: ☐	NO: ☐	IF YES, HOW MANY HOURS PER WEEK? _____
DO YOU TAKE VITAMINS/ SUPPLEMENTS?	YES: ☐	NO: ☐	IF YES, WHAT TYPE AND HOW MANY? _____

7. WHAT ARE YOUR HEALTH AND BEAUTY CONCERNS?

8. WHAT RESULTS WOULD YOU LIKE TO ACHIEVE?

9. WHAT IS YOUR CURRENT HEALTH AND BEAUTY ROUTINE?

10. HOW DID YOU HEAR ABOUT US?

Please sign to confirm the medical information given above is correct, to the best of your knowledge. Please confirm that you have discussed your medical profile with your therapist and any contraindications have been discussed and you consent to the commencement of your treatment.

Please note it is your responsibility to advise Virgin Active of any changes to your medical profile that may affect the safety of treatments within the Virgin Active Health & Beauty Spa.

CLIENT'S NAME: _____ SIGNATURE: _____ DATE: _____

THERAPIST'S NAME: _____ SIGNATURE: _____ DATE: _____