CONSULTATION CARD

Guest profile

Name:

Address:

Postcode: Mobile:

E-mail Date of birth:

PLEASE TICK IF YOU HAVE RECENTLY EXPERIENCED THE FOLLOWING:

- ☐ headaches
- ☐ back/spine concerns
- ☐ injury/surgery
- ☐ claustrophobia
- ☐ allergies
- ☐ asthma
- ☐ pregnancy_____weeks
- ☐ skin conditions
- ☐ chemical peel
- ☐ infection/illness
- ☐ blood pressure irregularity
- ☐ heart conditions
- ☐ varicose veins
- ☐ post natal_____weeks
- ☐ other (please specify): _____

Are you taking any medications? ☐ yes ☐ no Please specify:

Is there any further information you would like to provide that may affect your treatment today?

WHAT IS YOUR DESIRED OUTCOME:

- ☐ cleansing
- ☐ relaxing
- ☐ beautifying
- ☐ detoxifying
- ☐ relief or muscle tension
- ☐ energized
- ☐ uplifted
- ☐ product knowledge
- ☐ fitness
- ☐ nutritional knowledge
- ☐ other (please specify) : _____

WHAT IS YOUR BEAUTY REGIME AT HOME?

FACE:
- ☐ cleanser
- ☐ toner
- ☐ moisturizer
- ☐ exfoliant
- ☐ mask
- ☐ eye cream
- ☐ serum
- ☐ SPF

BODY:
- ☐ cleanser
- ☐ moisturizer
- ☐ body polish
- ☐ body oil
- ☐ instant tan
- ☐ SPF

Are there any particular areas of your body/face you would like to focus on today?

Are there any particular areas of your body/face you would like to avoid today?

PLEASE INDICATE YOUR PREFERRED LEVEL OF CONVERSATION DURING YOUR TREATMENT?

- ☐ I like conversation
- ☐ A little conversation would be lovely
- ☐ Little to no conversation, I'd prefer to relax

How did you hear about us?

WAIVER AND RELEASE OF LIABILITY FOR SPA SERVICES

I understand that it is my responsibility to inform Park Club Health & Day Spa of any changes to the information I have provided above. I am fully knowledgeable of the services or treatments that will be provided, as well as my own physical limitations, and I agree to assume the risk of accepting the services or treatments. I acknowledge that if I have any medical conditions, allergies, medications (oral or topical) that may be affected by the treatment or services requested, I have the opportunity to discuss such conditions with the service provider. I acknowledge that it is my sole decision to receive the services or treatments. If the therapy causes me any personal injuries, pain or discomfort, I will immediately advise the provider of this condition and cease further services. I understand that Park Hyatt Melbourne will make no evaluation nor recommendation –and I will not construe any statement or action as an evaluation or recommendation –with respect to whether I am sufficiently physically fit for the services or treatment requested.

I am aware that it is always advisable to consult a physician before undertaking such services.

I hereby release Hyatt Corporation, its parent and subsidiaries, officers, directors, agents, affiliates, employees, the owner of the Hotel and each of them (collectively, "Hyatt") from any and all claims, damages, demands, rights or causes of action, present or future, known or unknown, unanticipated, arising out of or in any manner resulting from therapeutic services provided by a therapist at the Hotel, including, without limitation, any claims, damages, demands, rights or causes of action resulting from or arising out of the negligence of Hyatt, the provider or any employee or agent of Hyatt. Further, I hereby agree to waive any and all of such claims, damages, demands, rights or causes of action. Such Release and Waiver is to be binding upon my heirs, executors, administrators and assigns. Further, I hereby agree to release and discharge Hyatt from any and all liability for any loss or theft of, or damage to, personal property.

- ☐ I acknowledge that I have carefully read this waiver and release and fully understand its implications.
- ☐ Please tick here if you do not wish to receive information and exclusive offers from Park Club Health & Day Spa.

Signature: Date:

Therapist: Date & time :

therapist notes: