Fairmont
HOTELS & RESORTS

Please take a moment to complete your profile (please print clearly)

Name _____ **Phone Number**_____

City_____ **Country** _____**Birthday**(M/D/Y)_____

Please take a moment to complete this confidential medical history form. This information is requested so your spa professional can better customize your experience to your needs and ensure the safety/efficacy of your spa experience. This information is confidential and does not become a part of your spa profile.

Is there a specific reason for selecting this treatment?

☐ **Relaxation**
☐ **Relief from muscle tension/soreness**
☐ **Arthritis** *(type & location)*
☐ **Other**

Do any of the following conditions apply to you? *(past or present)*

Allergies

☐ **Nut / Seed Allergies**
☐ **Latex Allergy**
☐ **Other** *(please identify)*

☐ **Asthma**
☐ **Arthritis** *(type & location)*
☐ **Bone Fractures** *(please identify)*
☐ **Bruise Easily**
☐ **Cancer / Related Treatments** *(please identify)*
☐ **Diabetes** *(please identify)*
☐ **Digestive Condition**
☐ **Dizziness / Negative reaction to heat** *(please identify)*
☐ **Epilepsy**
☐ **Head/Neck Trauma** *(please identify)*
☐ **Heart Condition** *(please identify)*
☐ **High Blood Pressure**
☐ **Kidney Disease**
☐ **Numbness / Tingling / Hypersensitivity** *(where?)*
☐ **Pregnancy** *(how many months?)*
☐ **Recent Surgery** *(please identify)*
☐ **Skin Conditions / Lesions / Plantar Warts**
☐ **Soft Tissue Sprains or Strains** *(please identify)*
☐ **Spinal Disk Injury / Disease** *(please identify)*

Do you have any other medical conditions or injuries not listed above?

Please list: _____

_____

Medications you are taking:

Please list: _____

_____

ACKNOWLEDGEMENT (must be completed by guests 18 years of age and older)

I acknowledge that I am least 18 years of age and that the treatments provided at Spa Fairmont at a Fairmont Hotel are not intended as a diagnosis and do not replace medical treatment. I further acknowledge that the information provided in this form is true, accurate and complete and that certain treatments may be refused to me on the basis of the information provided herein.

Signed:_____ **Dated:**_____

FOR OFFICE USE ONLY:

Therapist has been advised by guest that the information provided in this form is true, accurate and complete. (Therapist must complete the chart below.)

	Name of Therapist	Treatment(s) Provided	Date	Therapist's Signature
1.				
Notes:				
2.				
Notes:				
3.				
Notes:				
4.				
Notes:				
5.				
Notes:				