THE OASIS WELLNESS CENTRE & SPA
CONSULTATION QUESTIONNAIRE

It is our pleasure to welcome you to the Oasis Wellness Centre & Spa. So we can provide you with the best service possible, please provide the following information:

Date: ______________________________

Ms./Mrs./ Mr.

First Name: ______________________________

Last Name: ______________________________

Date of Birth: ______________________________

Occupation: ______________________________

How did your hear about us? ________________

Email: ______________________________

Telephone: ______________________________

Address: ______________________________

____

Postal Code: ______________________________

Physician/Naturopath: ______________________________ Tel: ______________________________

Dermatologist: ______________________________ Tel: ______________________________

ARE YOU:

Allergic to Iodine? Yes □ No □

Taking medication? Yes □ No □

Specify: ______________________________

Do you suffer from:

Claustrophobia Yes □ No □

Epilepsy Yes □ No □

DO YOU HAVE:

Eczema Yes □ No □

Psoriasis Yes □ No □

Nail Fungus Yes □ No □

Warts Yes □ No □

Open wounds Yes □ No □

Specify: ______________________________

Please list any concerns about your skin/body that you would like to discuss with us:

____

Would you be interested in information about Pure Medical Aesthetics? Y N

How would you rate your stress level today? 1 2 3 4 5

1= lowest 5= highest Explain: ____

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"Oasis" is the registered trademark of Oasis Wellness inc.

The participant is cautioned that spa treatments are not intended to replace proper medical attention for any condition. Te participant should not undertake any spa treatment without first consulting his/her physician. It is the participant's responsibility to alert Oasis to any pre-existing medical condition or injury. Oasis will not be held responsible for causing or exacerbating any personal injury unless that injury is caused solely by the gross negligence of Oasis or it's officers, directors, employees, or independent contractors. I have stated all my known medical conditions and take it upon myself to keep Oasis updated on my physical health.

Signature ______________________________ Date ______________________________

Over...

CONFIDENTIAL GUEST HISTORY:

CLINICAL DATA

Present injury/problem: ____________________

Is this the result of a motor vehicle accident? ____________________

Approximate date this condition began: ____________________

MUSCLES/JOINTS

Location of problem: ____________________

Dislocations: ____________________

Arthritis: ____________________

Surgery: ____________________

HEAD/NECK/BACK PAIN?

Head ☐ Neck ☐ Back ☐

Vision Problems	Yes ☐	No ☐	Headaches	Yes ☐	No ☐
Sinus Problems	Yes ☐	No ☐	Contact Lenses	Yes ☐	No ☐
Earaches	Yes ☐	No ☐			

RESPIRATORY

Smoker Yes ☐ No ☐ Shortness of breath Yes ☐ No ☐ Respiratory disease Yes ☐ No ☐

CARDIOVASCULAR

Blood Pressure High ☐ Low ☐ Heart Disease Yes ☐ No ☐

SKIN

Rashes	Yes ☐	No ☐	Varicose veins	Yes ☐	No ☐
Herpes	Yes ☐	No ☐	Phlebitis	Yes ☐	No ☐
Warts	Yes ☐	No ☐	Bruise easily	Yes ☐	No ☐

OTHER MEDICAL CONDITIONS

Cancer	Yes ☐	No ☐	Heart or chest pains	Yes ☐	No ☐
Faintness/dizziness	Yes ☐	No ☐	Teethe grinding	Yes ☐	No ☐
Tightness of jaw	Yes ☐	No ☐	Heavy feeling in limbs	Yes ☐	No ☐
Digestive problems	Yes ☐	No ☐	Tired legs	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	Cold hands/feet	Yes ☐	No ☐
Pregnant	Yes ☐	No ☐	Nervousness	Yes ☐	No ☐
Seizures	Yes ☐	No ☐	Insomnia	Yes ☐	No ☐
Urogenital disease	Yes ☐	No ☐	Excessive fatigue	Yes ☐	No ☐

Weakness in parts of the body Yes ☐ No ☐ Allergies: ____________________

Infectious diseases: ____________________

Please list the regular activities you participate in, and time per week: ____________________

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