

**TREATMENT NOTES**

Date ..... Treatment .....

Therapist .....

Client Concerns/Aims .....

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Treatment Notes .....

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Treatment/Rebooking Recommendations .....

Product Recommendations .....

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Product Recommendations .....

**AURORA SPA RETREAT™**

Welcome to Aurora Spa Retreat

Good health is a feeling of vitality, wellness, peace and balance. At Aurora we believe good health can be enhanced by living in harmony with nature's four seasons. Each spa treatment you have today will work towards balancing your body through the therapeutic value of the treatment and Aurora's balancing and awakening rituals.

Experience the ultimate in vitality and wellbeing by taking time out to relax, refocus and revitalize your senses.

Enjoy your journey.



If you are on retreat with us today or have a water therapy treatment you will be required to change into Spa PJ's/Robe and slippers. All Spa PJ's/Robe and slippers must be returned to our reception desk after your treatment time with us. Any items not returned will be charged directly to your credit card.

If you are with us today for any other treatment (eg: massage, facials, express treatments, hand/foot) there is no need to be changed into Spa PJ's/Robe and slippers.

**Items Given to Client**

**Locker Number:** .....

**Spa PJ's \$60.00 :**  Yes  No    **Robe \$75.00:**  Yes  No

**Slippers \$50.00:**  Yes  No    **Size:** .....

**Name:** .....

**Male**     **Female**                      **Date of Birth:**    /    /

**Postal Address & Postcode:** .....

**Occupation:**.....

**Company:**.....

**Mobile Phone:**.....

**Second Phone Contact:** .....

**E-mail:** .....

**Marital Status:** .....

**Children:** .....

**Emergency Contact:** .....

**Where did you hear about us?** (please tick)

- |  |  |
|--|--|
| <input type="checkbox"/> Friends/ Family           | <input type="checkbox"/> Radio                         |
| <input type="checkbox"/> I received a Gift Voucher | <input type="checkbox"/> Magazine/ newspaper           |
| <input type="checkbox"/> Web/Internet              | <input type="checkbox"/> Promotional Flyer             |
| <input type="checkbox"/> Billboard                 | <input type="checkbox"/> Other (please specify): ..... |

**Please indicate if any of the following are relevant to your current state of health:**

- |  |  |
|--|--|
| <input type="checkbox"/> Allergies                               | <input type="checkbox"/> Deep vein thrombosis                    |
| <input type="checkbox"/> Recent surgery                          | <input type="checkbox"/> Acute hypertension                      |
| <input type="checkbox"/> Heart condition or pulmonary deficiency | <input type="checkbox"/> Very high/low blood pressure            |
| <input type="checkbox"/> Infectious conditions                   | <input type="checkbox"/> Thyroid condition                       |
| <input type="checkbox"/> Cancer                                  | <input type="checkbox"/> Claustrophobia                          |
| <input type="checkbox"/> Epilepsy                                | <input type="checkbox"/> Spinal problem                          |
| <input type="checkbox"/> Varicose veins                          | <input type="checkbox"/> Females - Are you pregnant? ..... Weeks |

**How would you like to improve your health and wellbeing?:**

- |   |  |
|---|--|
| <input type="checkbox"/> Less stress                | <input type="checkbox"/> Assistance with weight management |
| <input type="checkbox"/> Better quality sleep       | <input type="checkbox"/> Detoxification                    |
| <input type="checkbox"/> Improved blood circulation | <input type="checkbox"/> Increase immune system            |
| <input type="checkbox"/> Release of muscle tension  | <input type="checkbox"/> Increased skin hydration          |
| <input type="checkbox"/> Less fluid retention       | <input type="checkbox"/> Less skin sensitivity             |
| <input type="checkbox"/> Improved energy levels     |  |

**Please provide details of any medication, recurring injuries, allergies (including food) or other health conditions:**

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.....

**When having a massage what pressure would you like?:**

- Relaxation     Firm     Deep     Very deep

**Are there any areas of your body you would prefer not to be worked on?:**

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**Regarding your beauty and skincare treatments, please specify frequency of application and type of product you currently use:**

Cleanser .....

Toner .....

Exfoliant .....

Moisturiser .....

Serum/Booster .....

Eye Cream .....

Mask .....

Body .....

Other .....

**How much water do you drink daily?** .....

**Prior to commencing your treatment, please read our standard Spa Policy and sign where indicated below to indicate that you accept these conditions.**

I understand that it is my responsibility to inform Aurora of any changes to the information I have provided above. I release Prince Aurora Pty Ltd ABN 077 916 806 and its successors, assigns, agents, invitees and employees ('Aurora') from all liability in contract or in tort or in any claim for negligence or otherwise arising from any loss or damage to my property or person, however caused, arising out of or in connection with matters including but not limited to products or services provided by Aurora: any fact, matter or thing relating to products or services provided by Aurora; any error (whether negligent or in breach of contract or not) in information supplied by Aurora before or after the date of supply.

**Signature:** .....

**Date:** .....