amatara

WELLNESS CONSULTATION

All information on this form will be kept strictly confidential.

Title: ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Ms. ❑ Other:	Date of Birth:	Age:
Family Name:	First Name:	
Nationality:	Country of Residence:	
Occupation:	Email:	
Emergency Contact:	Relationship to Guest:	

Package:	Room No:	Visit No:
Arrival Date:	Departure Date:	No. Nights:
For completion by Wellness consultant		
Height:	Weight:	
Blood Pressure:	Resting Pulse:	
Blood Type (if known):		

Objectives and Goals
What would you like to achieve, or what issues would you like to address, during your stay here? E.g. reduce stress, lose weight, improve fitness, quit smoking, etc. If more than one, what is your priority?
Do you have a particular motivation for wanting to achieve this goals?
What level of guidance would you like to receive in achieving these goals? 1☐ 2☐ 3☐ 4☐ 5

Medical History
Are you currently experiencing any illness, symptoms or injuries? ❑ Yes ❑ No If yes, please list, including how long have you been experiencing this problem?
Are you currently on any medication? Please list medication, dosage and frequency (medication includes vitamin supplements, contraceptive pills, herbs, etc.)
Please list any significant previous illnesses, symptoms or injuries, including date and duration.
Please list any operations that you have had, including cosmetic procedures, including approx. date.
Do you have other physical conditions, which cause pain? ❑ Yes ❑ No
Do you have a family history of any of the following: ❑ diabetes ❑ heart disease ❑ cancer ❑ blood pressure ❑ auto-immune disorders ❑ Other (please specify):

Lifestyle Overview

Diet

Are you happy with your diet and eating patterns? ☐ Yes ☐ No

Are you happy with your weight, size and/or shape? ☐ Yes ☐ No

Has your weight been stable, increased or decreased over the last year? By how much? ..... kg

Have you ever been on a dietary or weight loss plan? ☐ Yes ☐ No

If yes, please answer the following questions:

- How many diets have you been on in the last 2 or 3 years? .....
- Describe any diets you have tried (e. g., Atkins, Dukan, etc) .....
- Describe your experience with diets. Did you lose weight? Did you get any of it back? Did you feel tired or irritated? Why did you stop your diet? .....

Do you have any philosophy of eating (e.g., vegetarian, vegan, etc)?

Do you have food cravings? ☐ Yes ☐ No

Do you have any known food allergies or intolerances? ☐ Yes ☐ No

Describe your diet on an average day:

Breakfast:

Lunch:

Dinner:

Snacks:

How much of the following do you drink per day?

..... tea ..... coffee ..... water ..... alcohol ..... soft drinks ..... diet drinks

Exercise

Do you do any regular exercise? ❑ Yes ❑ No

If so, what type of exercise and how frequently do you do it?

How physically active are you in your work and/or in your normal daily life?

☐ Sedentary (e.g. desk job) ☐ slightly active (e.g. teacher) ☐ moderately active (e.g. nurse) ☐ very active (e.g. construction)

Would you like to improve your fitness, body shape or posture while at the resort? ❑ Yes ❑ No

If so, which of the following activities appeal to you (tick all that apply):

❑ Group exercise classes	❑ Personal training	❑ Water exercise / swimming
❑ Pilates / yoga	❑ Stretching	❑ Thai boxing / martial arts
❑ Walking / trekking	❑ Cycling	❑ Physio / rehabilitation

Stress

How would you rate the level of stress in your life? (1=lowest, 10=highest)

1. Work life 0
2. Personal life 0

How does stress effect you mentally/physically/emotionally?

How long has your stressful situation been affecting you?

How many hours do you work per day? ..... hours per day

Do you smoke? If yes, how many cigarettes per day? ❑ No ❑ Yes: ..... per day

Do you take any recreational drugs? ❑ Yes ❑ No

What do you do to relax?

Sleep

How many hours do you sleep per night? ..... How many do you feel that you need? .....

Do you have difficulty sleeping? e.g. falling asleep, waking early, snoring, sleep apnoea?

Do you use any sleeping aids? ☐ Yes ☐ No

How does your energy fluctuate during the day?

Do you have the most energy in the ☐ morning ☐ afternoon ☐ evening?

Emotions

Do you often experience anger, fear, anxiety, sadness, jealousy, worry, depression, suicidal feelings, frustration, mood swings, restlessness, stress, other? (circle)

Have you ever been treated for any of the above or felt the need for help? ❑ Yes ❑ No

Would you like to address any of these issues during your stay here?	❑ Yes ❑ No
Spirituality	
Do you currently have any form of spiritual practice?	❑ Yes ❑ No
Are you interested in developing spiritual practice?	❑ Yes ❑ No

Body Systems Overview

Musculoskeletal

Do you have any restriction, pain or stiffness during movement?

Where is it, when did it appear and how long has it been a problem?

Have you undergone any treatment for this?

Nervous System

Do you have any problems with sensitivity, weakness, numbness or tingling, especially in the extremities?

Reproductive-Urinary System

Are you pregnant? (For females) ❑ Yes, ... months ☐ No

Do you have regular prostate/gynecological exams/mammograms? ❑ Yes, ... months ago ☐ No

Do you have problems with any of the following? (tick all that apply)

❑ menstrual issues ❑ menopause ❑ thrush ❑ urinary tract infections ❑ prostate

❑ urination ❑ sexually transmitted diseases ❑ other (specify):

Circulatory System

Do you have any known cardiovascular problems? (tick all that apply)

❑ chest pain ❑ shortness of breath ❑ heart palpitations ❑ irregular heart beat ❑ heart murmur ❑ high or low blood pressure ❑ heart attack ❑ stroke

Do you have any other circulatory condition that concerns you? (tick all that apply)

❑ fluid retention ❑ varicose or spider veins ❑ cold or swollen hands, feet & legs ☐ cellulite ☐ removed or blocked lymph nodes?

Do you often feel faint or dizzy? ☐ Yes ☐ No Do you get hot or cold easily? ☐ Yes ☐ No

Digestive System

Do you suffer from any of the following digestive complaints? (tick all that apply)

❑ bad breath ❑ bloating / gas ❑ constipation ❑ Crohn's ❑ diarrhea ❑ heartburn ❑ hemorrhoids

❑ IBS ❑ indigestion ❑ mucous or blood in the stool ❑ nausea ❑ stomach cramps or pain

Immune System

Have had any recurrent infections, sore throats or colds over the last 12 months?	❑ Yes ❑ No
Have you taken antibiotics more than once in the last year?	❑ Yes ❑ No
Do you have skin conditions, or regular irritations in eyes, ears, scalp, etc.?	❑ Yes ❑ No
Do you have hay fever, sinus or asthma?	❑ Yes ❑ No
Do you have any food/supplements or medical allergies?	❑ Yes ❑ No

Other

Do you have or use any of the following:

❑ Contacts/Glasses ❑ Pacemaker ❑ Prosthesis ❑Metal pins ❑ Implants ❑ Hearing aid ❑ IUD

Wellness Treatments

List any spa or wellness treatments you receive regularly at home:

Do you have any objection or preference for the gender of your spa therapist? ❑ Male ❑ Female

I affirm that the information above provides a complete and accurate record of my current health and lifestyle, including all known medical conditions and any other information that may be relevant to my engaging in any of the treatments or services at (client). I am aware that all treatments and activities are undertaken at my own risk. I hereby absolutely and irrevocably release (client), its employees, representatives, agents or assignees from any claim, legal or otherwise, from accidents, injuries or outcomes that may occur as a result of my participation in any such activities, programs or treatments.

_____ _____

Guest Signature Date

_____ _____

Wellness Consultant Date

For Completion by Wellness Consultant
Priority Issues to Address
Diagnostics Recommended
Therapies & Activities Recommended
Education / Information Provided
Follow Up Consultation - Guest Feedback & Recommendations
Departure Consultation - Guest Feedback
Departure Consultation -