



Spa Break Health Questionnaire

Dear Guest

At Ragdale Hall we offer a wide range of facilities and activities, some of which may not be suitable for those guests with particular health problems. It is vital, therefore, that you complete the following questionnaire prior to arrival so that we may ensure your proposed treatments schedule is both safe and appropriate.

Please do not send the questionnaire to us in advance of your visit. However you can print it off and bring it with you if you would like to do so.

By handing this form to Reception on arrival our Treatments Administration Department will be able to assess your medical history and, only if necessary, arrange an appointment to discuss details further. If, however, you particularly wish to discuss your medical history with regard to the services offered at the Hall, our Treatments and Activities Administration Department are available for this purpose.

Please be aware that certain medical conditions may restrict the range of treatments and activities you can enjoy. Therefore in order to avoid disappointment on arrival we strongly recommend you contact us prior to your visit on 01664 433043 and advice. You can also call this number should you have any queries regarding our screening procedure.

We would also advise you to read the Health and Safety Guidelines before entering the spa and make sure Fitness Staff are aware of any health concerns.

Please note, however, that Ragdale Hall is not a medical centre and you are advised to visit your GP should you have any concerns regarding your current state of health.

Office Use Only

Locker No: FV: RV:

Contacted: YES NO

FULL NAME (Print in CAPITALS)

.....
Arrival Date Departure Date..... Date of Birth

Age (Min 16) Sex M / F Occupation

1. Are you aware that you have high or low blood pressure?
Yes / No (please delete)
Is it: High / Low (please delete)
Are you on medication?

2. Do you suffer from any form of Liver, Kidney or Stomach Disorders?
Yes / No (please delete) If yes, please state details.....

3. Do you suffer from any heart or circulatory problems i.e. thrombosis, stroke or varicose veins?
Yes / No (please delete) If yes, please state details.....

4. Do you have any form of disability or medical condition? i.e. partial sight or hearing, wheelchair user, epilepsy etc.
Yes / No (please delete) If yes, please state which.....

If yes please contact our Reservations Department on 01664 433000 at your earliest convenience.

5. Are you Diabetic?
Yes / No (please delete)
How is it controlled; Insulin / Tablets / Diet (please delete)

6. Have you had any operations or major dental treatments in the last 3 years?
Yes / No (please delete)
Date of operation..... Full details of operation.....

Gentlemen move directly to Question 10

7. Are you currently suffering or have you recently suffered from any gynaecological problems?
Yes / No (please delete)
Which?

When?

8. Are you currently pregnant?
Yes / No (please delete) Number of weeks.....

9. Are you breast-feeding?
 Yes / No (please delete)

10. Have you suffered from any form of cancer in the last five years?
 Yes / No (please delete) Which year?.....
 Details/area.....

11. Have you been treated by chemotherapy or radiotherapy?
 Yes / No (please delete) Which year?
 Details.....

If you have answered YES to questions 8, 9, 10 or 11 please contact our Treatments Advice Line prior to arrival as restrictions to certain treatments may apply. A Doctor's note may be required.

12. Do you suffer from any form of arthritis or rheumatism?
 Yes / No (please delete) Which areas?.....
 Details

13. Do you have a medically diagnosed back condition?
 Yes / No (please delete) If yes please give full details.....

14. Have you suffered from any broken bones in the past 2 years or have you any artificial joints, metal pins or rods in any of your limbs?
 Yes / No (please delete) Please give full details (i.e what and where)

Date.....

15. Do you suffer from severe asthma?
 Yes / No (please delete)
 Treatment or medication taken.....

16. Are you currently suffering from any fungal or contagious infections.
 Yes/No Which areas?.....
 Details.....

17. Do you have any allergies and what is the reaction?
 Yes / No (please delete) Details.....

Do you use an epi-pen? Yes / No (please delete)

18. Do you have any dietary requirements?
 Yes / No (please delete)
 Details

I will self manage dietary requirements

Please note – whilst we endeavour to guide you during your stay it is ultimately your responsibility to ensure your food choices, exercise and spa activities, and the treatment selection is suitable for your current state of health.

If you feel there is any other significant information regarding injury, illness or medication you may be currently taking which has not been covered in the above questions, please give details below.

Depending on the conditions identified above we may advise that you do not proceed with certain treatments without a doctor's note or your agreement that the treatment is conducted against our advice. The most common examples would be where you have answered 'Yes' to questions 1, 3, 8 or 13 where we would advise avoiding several treatments including massage.

If you wish to continue with your chosen treatments you might be required to sign the treatment disclaimer below or alternatively discuss the details with ourselves and your doctor prior to arrival.

I hereby declare that the above stated information is correct. I acknowledge the advice that I should consult my GP prior to undertaking treatments and activities recommended to me whilst staying at Ragdale Hall. I confirm that neither Ragdale Hall (1990) Ltd nor its representatives are responsible to me in incidence of illness or injury occurring whilst visiting the Hall or as direct result thereof.

RAGDALE HALL (1990) LTD
Treatment Disclaimer

Due to medical conditions stated on your health questionnaire, Ragdale Hall recommends that you do not proceed with any treatments without your doctor's written approval.

We can accept no liability for injury, discomfort or complications suffered during treatment(s) where this may be linked directly or indirectly to your existing or previous medical conditions.

Given the advice above, if you would like to proceed with your treatments please sign below.

SIGNED AS CONSENT TO THE ABOVE

.....
 Date.....