



CONFIDENTIAL CLIENT INFORMATION AND HEALTH HISTORY ~ Facial Massage

First Name: _____ M.I. _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (h): _____ (c): _____ Birth Date: ____ / ____ / ____

Email Address: _____ Marital Status: _____

Male Female Referred by: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

General Health Information:

Are you pregnant? Yes___ No___ Have/Had Skin Cancer? Yes___ No___

Do you have Psoriasis? Yes___ No___ Do you wear contacts? Yes___ No___

Do you have Eczema? Yes___ No___ Are seeing a dermatologist? Yes___ No___

Do you have TMJ? Yes___ No___ Are seeing an aesthetician? Yes___ No___

Are you currently using any of the following products? (Please circle)

Accutane	Antibiotics	Benzoyl Peroxide	Cortisone
Retin-A	E-mycin-T	Gylcolic Acid	Salicylic Acid
Sulfer	Vitamins	SPF	Prescription medication

What are your skin concerns? (Please circle)

Acne/Blemishes	Dull Skin	Fine Lines/Wrinkles	Dark Circles
Oily	Flakiness	Reduced Elasticity	Puffy Eyes
Large Pores	Deep Lines	Broken Capillaries	Dark Patches

Please list all food/cosmetic allergies: _____

What do you hope to accomplish from today's facial massage? _____

Which best describes your skin?

Normal___ Combination___ Dry___ Dehydrated___ Oily___ Sensitive___

Are there any other concerns/conditions not listed here that should be noted? _____ If yes, Please describe: _____

The above information is accurate and true to the best of my knowledge. I understand that the therapeutic session I receive is provided for the basic purpose of relaxation and skin care. If I experience any pain or discomfort during a facial massage/bodywork session, I will immediately inform the therapist. I understand that massage therapists do not diagnose disease, prescribe medications or manipulate bones. I further understand that massage therapy is not a substitute for medical attention and examination. I take full responsibility for alerting my practitioner to any physical, mental or emotional changes that occur with my health. I also understand that cancelled or missed appointments without 24 hours notice (medical emergencies excluded) may be charged in full for the price of the missed session.

Signature _____ Date: _____