

NAME _____ DATE _____
(LAST) (MIDDLE) (FIRST)
 ADDRESS _____ CITY _____ STATE _____ ZIP _____
 PHONE _____ EMAIL _____ BIRTHDAY _____
 THERAPIST _____ REFERRED BY _____

In order to provide you with the safest and most effective treatment, we request that you fill out this form accurately and thoroughly. This information will be kept completely confidential and be used only by our professional staff. Mahalo.

FACIAL ANALYSIS

- 1. SKIN TYPE**
 Normal Dry Combination Oily
 Sensitive/Breakout Very Sensitive/Rosacea
 Acne Mature
- 2. WHAT ARE YOUR PRESENT SKIN CONCERNS?**
 Please Check All That Apply
 Acne Lesions (cysts) Papules (inflamed) Blackheads
 Acne Scars Pustules (inflamed) Whiteheads
 Dilated Capillaries Enlarged Pores Ingrown Hairs
 Hyperpigmentation (brown spots from sun, scars, hormonal)

- 5. HAVE YOU RECENTLY UNDERGONE SURGERY?**
(MEDICAL OR COSMETIC)
 What? _____

 When? _____

- EYE AREA**
 Crow's Feet/Wrinkles Puffiness
 Lack of Elasticity Dark Shadows

- 6. HAVE YOU EVER BEEN PRESCRIBED ACCUTANE®?**
 If YES, last date used? _____
- 7. ARE YOU CURRENTLY TAKING ANY MEDICATIONS?**
 (e.g. Blood Thinner, Heart Medication, etc) **Please List:**

- MOUTH AREA**
 Wrinkles Hyperpigmentation Nasolabial Folds

- 6. DO YOU USE ANY OF THE FOLLOWING?**
 Eye Make-Up Remover Brand _____
 Cleanser Brand _____
 Toner Brand _____
 Moisturizer Brand _____
 Exfoliator Brand _____
 Mask Brand _____
 Make-Up Brand _____
 Sunscreen Brand _____

- CHEEK AREA**
 Loss of Elasticity Cross Wrinkling (sun damage)
 Hyperpigmentation Uneven Texture
 Dilated Pores Visible Capillaries

- 7. HAVE YOU EVER BEEN DIAGNOSED WITH..?**
 Skin Cancers Contact Dermatitis
 Seborrhea Eczema Hemophilia
 HIV/AIDS Herpes Hepatitis

- NECK & DÉCOLLETÉ AREA**
 Wrinkles Lack of Elasticity
 Severe Sun Damage Hyperpigmentation

- 3. HOW OFTEN DO YOU RECEIVE A FACIAL?**
 Regularly Seldom Never
- 4. HAVE YOU RECENTLY RECEIVED ANY OF THESE SERVICES?**
 Microdermabrasion Date _____
 Enzyme Peels Date _____
 Acid Peels Date _____
 Waxing Services Date _____

- 8. IF THERE IS ANYTHING YOU COULD CHANGE ABOUT YOUR SKIN, WHAT WOULD IT BE?** _____

The information I have provided is accurate and complete to the best of my knowledge. I understand that aestheticians do not diagnose or treat disease, and that any care or recommendation from this facility or from my aesthetician is not a substitute for a medical professional's care. I take responsibility for alerting my aesthetician of any changes to my health status and medications, as well as any responses perceived to be a result of the treatment as soon as I become aware of them. I also understand that no sexual activity, comment or innuendo will be tolerated. The staff reserves the right to refuse services at its discretion based on client's conditions, aesthetician's skill set, client attitude or action, etc., without explanation or prior notice, and I agree to this policy.

 SIGNATURE DATE

BODY ANALYSIS

1. **HAVE YOU RECEIVED PROFESSIONAL MASSAGE BEFORE?** Yes No
2. **IF YOU HAVE, HOW OFTEN DO YOU RECEIVE A MASSAGE?** Weekly Monthly Whenever
3. **WHAT MASSAGE PRESSURE DO YOU PREFER?** Light Medium Firm
4. **WHAT ARE YOUR GOALS FOR TREATMENT?** Relaxation/Stress Reduction Pain Relief Wellness
5. **ANY AREAS OF TENSION/SORENESS? Please List All.** _____
6. **ARE YOU CURRENTLY UNDER A PHYSICIAN'S CARE?** No Yes *If yes, FOR WHAT CONDITION?* _____
7. **ARE YOU CURRENTLY (within the past few days) SUFFERING FROM ANY OF THE FOLLOWING?**
 Cold/Flu Fever Allergies Migraine Headaches Sinus Headaches
8. **HAVE YOU SUFFERED ANY INJURIES IN THE PAST TWELVE (12) MONTHS? PLEASE LIST ALL.** _____
9. **DO YOU HAVE ANY BODY IMPLANTS?** Pacemaker Metal Plates, etc. Prosthetics Other _____
10. **ARE YOU CURRENTLY UNDERGOING CHEMOTHERAPY OR RADIATION THERAPY?**
 No Yes (Please Specify) _____
11. **DO YOU SUFFER FROM ANY ALLERGIES? (Cosmetic Ingredients, Food, Iodine, Medications, Hay Fever, Latex, etc.)**
Please List. _____
12. **ARE YOU CURRENTLY TAKING ANY MEDICATIONS? (i.e. blood thinner, heart medication, aspirin, herbs, vitamins, etc.)**
Please List. _____
13. **HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING? Please Check All That Apply.**
 Anemia Blood Clots/Phlebitis Depression Heart Attack HYPER-Thyroidism Stroke
 Anxiety Broken Bones Epilepsy Hepatitis HYPO-Thyroidism Spinal Injuries
 Asthma Cancer (specify) _____ HIGH Blood Pressure HIV/AIDS Migraines Ulcers
 Arthritis Diabetes LOW Blood Pressure Herpes Seizures Varicose Veins
14. **HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING SKIN CONDITIONS? Please Check All That Apply.**
 Athlete's Foot Contact Dermatitis Eczema Fungal Infections Psoriasis Seborrhea Skin Cancers
15. **FOR WOMEN ONLY:**
 Pregnant Lactating Menopause Birth Control Pill Hormonal Problems IUD (copper or plastic)
16. **DO ANY OF THE FOLLOWING APPLY TO YOU?**
 Smoke Wear Contact Lenses Dentures Exercise Eat Spicy Food
17. **HOW OFTEN DO YOU CONSUME ALCOHOL?** Regularly Seldom Never
18. **HAVE YOU RECEIVED A BODY TREATMENT AND/OR BODY WRAP BEFORE?** Yes No
19. **IF YOU HAVE, HOW OFTEN?** Weekly Monthly Whenever
20. **WHAT ARE YOUR PRESENT CONCERNS? Please Check All That Apply.**
Dry/Flaky Skin Arms Legs Elbows Knees Chest Feet Back
Oily Skin and/or Breakout Back Chest
Loss of Elasticity Breasts Buttocks Inner Arms Inner Thighs Mid Torso
Cellulite Buttocks Thighs Back of Arms Stomach
21. **IF YOU COULD IMPROVE ONE THING ABOUT YOUR BODY, WHAT WOULD IT BE?** _____

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