Massage Academy of the Poconos - Consultation Card

Name:_____

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

Home Phone#:_____ Work:_____ Cell:_____

Occupation: _____

Physician: _____

Age:_____ Date of Birth:_____ Referred by:_____

Primary Reason for Appointment:_____

Email Address:_____

YOUR HEALTH

Within the last year, have you been under a dermatologist or other physician's care? Yes_____ No_____

If yes, please specify:_____

Within the last nine months, have you undergone any surgery? Yes_____ No_____

If yes, please specify:_____

List any medications, supplements, vitamins, diuretics, slimming tablets etc. that you take regularly:_____

_____

Do you smoke?_____ Do you exercise regularly?_____

Do you follow a restricted diet?_____ Do you wear contact lenses?_____

Do you have metal implants, a pacemaker or body piercings?_____

Rate your level of stress on a scale of 1 to 4 (1=low stress, 4=high stress)_____

YOUR SKIN

Do you have any special skin problems pertaining to your face or body? Yes_____ No_____

If yes, please specify:_____

What skin care products are you currently using?
Face: ___soap ____cleanser ____toner ____moisturizer ____masque ____exfoliate ____eye products

Body: ____soap ____shower gel ____scrubs ____oil ____body moisturizer ____depilatory products _____self tanner

EXFOLIATION HISTORY

Have you ever had chemical peels, micordermabrasion, or any resurfacing treatments? Yes_____ No_____

In the last month? Yes_____ No_____

Do you use Accutane, Rentin A, Renova, Adapalene or any other prescription skin products? Yes____ No____

In the last 3 months? Yes_____ No_____

Are you currently using any products that contain the following ingredients?

____glycolic acid ____lactic acid ____any exfoliating scrubs ____any hydroxy acid product

____vitamin A derivatives (i.e. retinol)

MOISTURE HYDRATION

How much plain water do you consume daily?_____

How many alcoholic beverages do you consume weekly?_____

Have you consumed alcohol in the last 24 hours? Yes_____ No_____

Please indicate any cough suppressants or tonics with alcohol content you are currently using:_____

Do you ever experience these conditions on your skin? ____flakiness ____tightness ____obvious dryness

What spf sunscreen do you use on your face?_____ body?_____

Do you sunbathe or use tanning beds? Yes_____ No_____

CAPILLARY ACTIVITY

Do you burn easily in moderate sunlight? Yes_____ No_____

Do you blush easily when nervous? Yes_____ No_____

Do you have a tendency to redness? Yes_____ No_____

Do you suffer from sinus problems? Yes_____ No_____

OIL SECRETION

Do you ever experience oily shine during the day? Yes_____ No_____

Do you ever experience skin breakouts? Yes_____ No_____

NERVE ACTIVITY

Do you drink more than 4 caffeinated beverages daily?(coffee, tea, soft drinks) Yes_____ No_____

Do you ever experience a burning, itching sensation on your skin? Yes_____ No_____

What is your pain threshold? low_____ medium_____ high_____

Have you ever experienced claustrophobia? Yes_____ No_____

NERVE ACTIVITY

What type of massage pressure do you prefer? light_____ medium_____ firm_____

Have you ever had a reaction to any of the following? ____cosmetics ____medication ____iodine ____pollen

____food ____hydroxy acids ____animals ____fragrance ____sunscreens other_____

WAXING

Have you ever been waxed? Yes_____ No_____

Have you ever had an allergic reaction to wax? Yes_____ No_____

Do you go to tanning salons? Yes_____ No____ Within the last 24 hours? Yes____ No____

FEMALE CLIENTS ONLY

Are you taking oral contraception? Yes____ No____ Are you lactating? Yes____ No____

Are you pregnant or trying to become pregnant? Yes_____ No_____

MALE CLIENTS ONLY

What is your current shaving system? electric____ wet shave____

Do you experience irritation from shaving? Yes____ No____ Do you experience ingrown hairs? Yes____ No____

QUESTIONS TO DISCUSS EVERY VISIT

Are you currently having or due for your menstrual period? Yes_____ No_____

Have you started any new medication since your last visit? Yes_____ No_____

Have you had any recent dental x-rays? Yes_____ No_____

What are your skin care goals?_____

_____

I confirm to the best of my knowledge that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment.

Client signature	Date	Client signature	Date
Client signature	Date	Client signature	Date
Client signature	Date	Client signature	Date
Client signature	Date	Client signature	Date

This consultation card is to correctly evaluate your special skin care needs. This information is confidential and may be disclosed only to staff members to assess the quality of care and will not be passed on to a third party.

I hereby consent to and authorize Massage Academy of the Poconos esthetician to perform any of the following procedure: Facials, Waxing or Body Treatements.

I have voluntarily elected to undergo this treatment/procedure after the nature and purpose of this treatment has been explained to me, along with the risks and hazards involved, by Massage Academy of the Poconos Esthetician. Although it is impossible to to list every potential risk and complication, I have been informed of possible benefits, risks, and complications. I also recognize there are no guaranteed results and that independent results are dependent upon age, skin condition, and lifestyle and that there s the possibility I may require further treatments of the treated areas to obtain the expected results at an additional cost.
I have read and understand the post-treatment home care instructions. I understand how important it is to follow all instructions given to me for post-treatment care. In the event that I may have additional questions or concerns regarding my treatment or suggested home product/post-treatment care, I will consult the esthetician immediately. I have also, to the best of my knowledge, given an accurate account of my medical history, including all known allergies or prescription drugs or products I am currently ingesting or using topically. I have read and fully understand this agreement and all information detailed above. I understand the procedure and accept the risks. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. I do not hold the esthetician, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this skin care procedure, which may be affected by the treatment performed today.

Client Name (printed) _____

Client Name (signature) _____Date _____

Esthetician _____Date _____

As the parent or legal guardian of _____ (minor's name), I give permission for her/him

to have the following services performed:_____

I confirm that I have read and understand all information on the applicable forms for this treatment or service, and accept responsibility on my child's behalf for any disclosures or liability described on those forms. I agree to supervise any home care procedures that are recommended as a result of the treatment.

Date:_____

Full name of parent or guardian:_ _____

Signature of parent or guardian:_____

Signature of esthetician:_____
This form must be signed in person by the parent or guardian at the time of service, witnessed by the esthetician.

Waxing Consent

What is your menstrual cycle due date?_____
(Always allow five days for menstrual cycle. Because of water retention and for your own personal comfort, you should avoid hair removal two days before your cycle is due and two days after it is completed.)

Please note that waxing does have certain side effects such as skin removal, redness, swelling, tenderness, etc. I have read the ab information and if I have any concerns, I will address these with my skin therapist. I give permission to my therapist to perform the w procedure we have discussed and will hold her and her staff harmless from any liability that may result from this treatment. I have g accurate account of the questions asked above including all known allergies or prescription drugs or products I am currently ingesti or using topically. I understand my esthetician will take every precaution to minimize or eliminate negative reactions as much as pos I have read and understand the post-treatment home care instructions. I am willing to follow recommendations made by my esthetic for a home care regimen that can minimize or eliminate possible negative reactions. In the event that I may have additional questior concerns regarding my treatment or suggested home product / post-treatment care, I will consult the esthetician immediately.
I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have rea fully understand the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered. I u the procedure and accept the risks. I do not hold the esthetician, whose signature appears below, responsible for any of my conditic that were present, but not disclosed at the time of this skin care procedure, which may be affected by the treatment performed toda

Client Name (printed) _____

Client Name (signature) _ _____ Date_____

Esthetician_____ Date_____

STAFF USE ONLY

TREATMENT/PRODUCT RECORD

Date	treatment/products used in treatment/contraindications/notes	samples given	therapist