CLIENT CONSULTATION FORM

Name: ____ Date: _____________________________

Address: ____________________________ City: _______________ State: ______ Zip: _______

Date of Birth: _______________________ Phone Number: _______________________________

Occupation: ______________________________ Email: _________________________________

If you are here for massage therapy services, what sort of pressure do you prefer?

☐ Light ☐ Medium ☐ Firm ☐ Deep

What are your main skin concerns?

____

What skin care products have you used or are currently using?

____

Have you received Botox/fillers in the past? ☐ Yes ☐ No

If yes, what was the date of your last injection? (mm/dd/yyyy) _____/_____/_____

Client Signature: ____

MEDICAL HISTORY

Check the box where applicable/ Fill in with details:

- ☐ Accutane
- ☐ Acne
- ☐ Allergies

  ____
- ☐ Blood Thinner
- ☐ Cancer
- ☐ Diabetic
- ☐ Eczema
- ☐ Epilepsy
- ☐ Heart Condition
- ☐ Hepatitis
- ☐ Herpes Simplex *(any form)*
- ☐ HIV/AIDS
- ☐ High Blood Pressure
- ☐ Medications

  ____
- ☐ Pacemaker
- ☐ Past injuries

  ____
- ☐ Pregnant (_______ weeks)
- ☐ Psoriasis
- ☐ Recent Surgeries *(including plastic)*

  ____
- ☐ Retin-A©
- ☐ Skin Cancer

  ____
- ☐ Varicose veins