



Client Profile and Records

Name Date

Home Address

Home Phone Work or Mobile Phone

Date of Birth Email

Please respond to the following: **YES** **NO**

1. Have you seen a doctor in the past year for a skin disorder? Yes No
2. Are you experiencing any skin problems now? Yes No
If yes, please explain
3. Have you ever had acne? Dermatitis Eczema Psoriasis Seborrhea
Herpes Simplex Foot Fungus or Warts When?
4. Have you undergone any facial cosmetic surgery, chemical peel and/or microdermabrasion? Yes No
If yes, please explain
5. Are you currently under a doctor's care for anything else? Yes No
If yes, please explain
6. Are you currently taking any prescription drugs? Yes No
If yes, please list and explain
7. Have you ever reacted unfavorably to any skin care product? Yes No
If yes, please list and explain
8. Please check all products that you have used within the last 30 days.
Retin-A Benzoyl Peroxide Alpha Hydroxy Acids Self-Tanners

Buff Puffs Granular Scrubs Hydroquinone Other Chemical Exfolinats
9. Have you ever used any of the above products in the past? Yes No
If yes, please list and explain
10. Do you exercise regularly? Yes No
11. Approximately how many cups of liquid do you drink each day?
Water Coffee/Tea/Cola Juice Alcohol Other

12. Are you pregnant? Yes No

13. Do you smoke? Yes No

14. Do you wear contact lenses? Yes No
If yes, please remove them for our sessions.

15. Describe your skin? Extremely Dry Dry Oily Combination

16. What are your goals for your Bellanina Facelift Massage session?

17. Please check all products you are currently using on your skin and the frequency:

Product	Daily	Occasionally	Brand Name
Cleanser			
Toner			
Moisturizer			
Eye Cream			
Facial Scub/Peel			
Masque			
Retin-A			
Glycolic Acid			
Sun Block			
Other			

I have listed all my known medical conditions and physical limitations and I will inform my massage therapist of any changes in my physical health. The Massage Therapist does not diagnose any medical, physical, or mental disorder nor prescribe medication or perform any spinal manipulations. I am responsible for consulting a qualified physician for any physical ailments that I may have. I understand the statements above and release the Massage Therapist and the UNC Wellness Center at Meadowmont from any and all claims of malpractice, non-disclosure, or lack of informed consent. I freely assume any and all risks of treatment whether presently contemplated or hereinafter discovered.

I understand that I am responsible for all payments of services rendered to me unless prior arrangements have been made. I understand that I will be responsible to pay for all appointments scheduled to me unless I call at least 24 hours prior to my appointment time to cancel or reschedule.

Signature

Date:

Print Name