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 tanners

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 cared 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.