

**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, Retin 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

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 Treatments.

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 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 is 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 above information and if I have any concerns, I will address these with my skin therapist. I give permission to my therapist to perform the waxing procedure we have discussed and will hold her and her staff harmless from any liability that may result from this treatment. I have given an accurate account of the questions asked above including all known allergies or prescription drugs or products I am currently ingesting or using topically. I understand my esthetician will take every precaution to minimize or eliminate negative reactions as much as possible. I have read and understand the post-treatment home care instructions. I am willing to follow recommendations made by my esthetician for a home care regimen that can minimize or eliminate possible negative reactions. 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 agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read and fully understand the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered. I understand the procedure and accept the risks. 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 \_\_\_\_\_

