Touch Of Tranquility MASSAGE

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Aesthetician Services Intake and Consent Form

This form must be completed and signed before receiving facial services

Today's Date: __/__/__ NAME: ___________________________ D.O.B:________________

General & Medical Information

Are you now or have been under the care of a physician within the last two years? Yes__ No__
If yes, please provide Physician's Name, address and phone number.

List all medications you are currently taking, including Retin A, Glycolic Acid and Accutane? ________________________________
List any drug, makeup, skin or food allergies (ie; soaps or nuts/fruits)? ____
How much water do you consume each day? ____
Which skin care products do you currently use? ____
Have you ever had a chemical peel, laser, microdermabrasion, Botox, collagen injections, or any skin resurfacing treatments? If yes, list each with date of last treatment. ____
Do you use acne medication? Which kind and how has your skin reacted?____
Do you experience breakouts? Yes___ No ___
Have you had an adverse reaction to any product? If Yes please describe:____
When was the last time you received a facial treatment? Describe:_________________________________
What are your skin care goals? ____

Do you have or have had any of the following conditions (circle Yes or No)

Yes No Abnormal Heart Condition
Yes No Fainting Spells/Dizziness
Yes No Cancer
Yes No Cold Sores
Yes No Cataracts
Yes No Tumors/Cysts/Growths
Yes No Herpes Simplex
Yes No Glaucoma
Yes No Chemo/Radiation
Yes No Hemophilia
Yes No "Dry Eye"
Yes No Are you pregnant?

Yes No High or Low Blood Pressure
Yes No Hepatitis
Yes No Prolonged Bleeding
Yes No Eye Surgery/Injury
Yes No Do you wear contact lenses
Yes No Circularly Problems
Yes No Do you smoke?
Yes No Epilepsy
Yes No Are you using eye drops or other ocular medications
Yes No Blepharoplasty (eyelid surgery)

Yes No Sun Bathe/tanning beds
Yes No Corneal Abrasions
Yes No Diabetes
Yes No Wear SPF?
Yes No Taking Oral contraceptives
Yes No Currently Menstruating
Yes No Visual Disturbances
Yes No Have you experienced hyperpigmentation from an injury?
Yes No Are you currently taking aspirin or ibuprofen?

When was last eye exam? __/__/__ Physician: ____

If I experience any pain or discomfort during the session, I will immediately inform the aesthetician so that the products and/or technique may be adjusted to my level of comfort. I further understand that facial should not be construed as a substitute for medical examination, diagnosis, or treatment. I understand that Aestheticians' are not qualified to perform, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because certain treatments should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I **agree** to keep the aesthetician **updated** as to any changes in my medical profile during the session and understand that there shall be no liability on the aestheticians part should I fail to do so. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session. I also understand that the Licensed Aesthetician reserves the right to refuse to perform treatments on anyone whom he/she deems to have a condition for which facial treatments are contraindicated.

Client Signature____ Date__________________