

Indian Face Massage Client Consultation Sheet

The following information is required for your safety & to benefit your health. All information will be treated in the strictest of confidence & will not be discussed or passed onto a third party.

Name:.....

Date of BirthOccupation:.....

Address:

.....

Telephone:.....Email:.....

Emergency telephone number & contact name?

Name:Tel No

Do you suffer with, or have you ever suffered from any of the following:

(If yes, tick box and also please give details)

- Diabetes
- Kidney problems
- Epilepsy
- Photosensitivity
- Surgery or injury to back or joints
- Sensitive skin
- Varicose Veins
- Deep vein thrombosis
- Heart disease
- High or low blood pressure
- Cancer
- Stroke
- Asthma
- Migraines Headaches regularly
- Eczema
- Psoriasis
- Severe Acne
- Spots / Blemishes
- Conjunctivitis
- Abscess and Boils
- Cold Sores
- Rosacea
- Blackheads & Whiteheads
- Impetigo
- Warts
- Lentigo (also known as Hutchinson's Freckle when malignant)
- Sinusitis
- Sties
- Skin Tags
- Chloasma (also called melasma or The Mask of Pregnancy when it occurs in pregnant women)
- Vitiligo
- Port Wine Stain
- Skin Cancer

- Are you wearing contact lenses?
- Do you have any allergies?

Give details:

.....
.....

What is your skin type? Dry / Oily / Sensitive / Mature / Combination Skin

- Dry
- Oily
- Sensitive
- Normal
- Mature (Early signs / Middle Age / Elderly)
- Combination Skin

Comments:

Are you currently taking any prescribed or self-prescribed drugs or remedies? (If yes, please give full details)

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In the next 12 hours, will you be:

- Driving
- Operating heavy machinery
- Drinking alcohol
- Using a sun bed or exposing your skin to ultraviolet light

Women only:

- Is there any possibility you might be pregnant?
- Are you currently menstruating?

If I had to call an ambulance is there anything they should know?

If yes, please give details

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Is there anything else that the therapist should be made aware of?

Details

I confirm that the information given above is correct and complete. I will inform my therapist before receiving treatment if any of the information above changes and at any time during my treatment. I understand that I am responsible for my own health, wellbeing and safety.

Signed: Date:

Identifying any Problem Areas

<p>Skin Type? Normal / Dry / Oily / Combination</p>	
<p>Skin Tone? Skin Firm / Skin sagging</p>	
<p>Symmetry? Lines that caused by ingrained expressions & wrinkles</p>	
<p>Puffiness? Restricting flow of lymph. Areas prone are the eyes & jaw line.</p>	
<p>Expressiveness? A mask like quality indicating deep seated muscle tensions.</p>	
<p>Lines or wrinkles? Areas needing extra attention.</p>	
<p>Restrictions? Areas may look as if something is preventing them moving freely. This is due to the restrictions in the connective tissue.</p>	
<p>Special areas? Scars, injuries or other special areas.</p>	
<p>Client's priorities? These may be different to what you see presented.</p>	

<p>Therapist Comments Ask Client to: Lift eyebrows, Frown, Laugh, Pucker lips</p>

