SKINCARE

Client Information and Informed Consent Sheet

In order to serve you better and make the most or your session, please fill this form out PRIOR to attending your session. Thank you!

PLEASE PRINT

B
CC
TY

DATE: _____

SECTION 1: CLIENT INFO

NAME_____DOB_____/_____/_____

ADDRESS_____CITY_____STATE _____ZIP_____

PHONE ❑ mobile ❑ home _____Mobile provider _____

(to receive a text appointment reminder)

EMAIL_____

(You will be added to the TaoMassage business list and receive periodic annoucements, promotions, etc)

❑ DO NOT ADD ME TO EMAIL LIST

CIRCLE ONE ANSWER:

I would like serivices performed at: TAO 611 Bangs Avenue / at another location

I would / would not like notes to be kept on my progress/services received at TAO.

SECTION 1: BACKGROUND INFO (please circle)

1. What **type of massage** do you prefer? soft medium firm
2. FEMALES: Are you pregnant? Yes No Maybe
3. Are you wearing **contact lenses** today? Yes No
4. **ALLERGIES** and REACTIONS to any of the following (please circle):

Pollen	Cosmetics	Fruit
Essential oils	hydroxy acids(i.e. glycolic, salicylic)	Medicine
Sunscreens	skin care product, if yes which?	Iodine
Shellfish	Fragrance	OTHER
Animals	Food	

5. **Have you ever been under a dermatologist's care?** Yes No
   if YES, When? _____ For how long? _____
   For what condition/s? _____
6. **Have you ever had a skin treatment before?** Yes No
   If YES: WHEN was your last facial? within 3-6mos Longer than 6mos ago
   What did you like about the experience? _____
   What did you dislike about the expereince?_____

SECTION 2: EXFOLIATION AND BLEACHING HISTORY (please circle)

1. Have you **ever had any** of the following, indicate date of treatment

chemical peels	laser
microdermabrasion	any resurfacing treatments?

2. Are you **using any of the following** products, if yes indicate when last used:

Accutane Differin Adapalenee Retin A Renova, Tazorac

3. **Acne medication**? yes no If yes, when and which drug?_____
4. Are you **currently using any products** that contain the following ingredients?

Glycolic Acid	exfoliating scrubs	Sulfur
Lactic Acid	Hydroxy acid products	Cleocin-T
Salicylic Acid	Sulfur	
Cortisone	Vitamin A derivatives (i.e. Retinol)	

5. Have you ever used a **bleach or fade cream** or and over-the-counter product?

   Hydroquinone Kojic Acid Over-the-counter product: _____

   Did you experience an allergic reaction to the bleach or fade cream such as:

   swelling itching fine bumps
6. Any **topical medications** that cause you to peel?

   Oral or Topical Antibiotics Steroids (Prednisone) Blood Thinners

SECTION 3: YOUR SKIN (please circle)

1. Describe your **skin type**.

   Normal oily combination (oily in T-Zone) acne prone

   water dry oil dry

2. What skin care products are you **currently using**?

   soap cleanser exfoliant masque moisturizer

   toner/astringent eye care sunscreen others

3. On a scale of 1 to 10 (10 being the most sensitive) how sensitive is your skin?

   1 2 3 4 5 6 7 8 9 10

4. **YOUR SKIN CONCERNS**:

❑ excess oiliness	❑ hyperpigmentation (sunspots or marks from breakouts)
❑ breakouts and blackheads	❑ redness/sensitivity or uneven complexion
❑ tired, dull skin	❑ would like smoother, more refined texture
❑ dry skin	❑ puffy eyes
❑ lack of firmness/elasticity	❑ dry/fine lines around eyes
❑ interested in anti-aging solutions	

Please read the following statement carefully, then sign below.

I I understand fully that services provided at TaoMassage are not a substitutes for medical examinations and/or diagnosis and that it is recommended that I see a physician for any physical ailment I may have. I also understand that failure on my part to disclose information could result in injury and/or illness and I hereby release TaoMassage and its agents from any claims resulting in such. I have stated all known medical conditions and take it upon myself to keep my service provider therapist updated on my physical health.

I I understand thay any information given is stricly confidential and will be used for no other purpose than to assist your service provider in provinding suitable treatment which would take into consideration my specific requirements.

I I understand that any illicit or sexually aggressive remarks, advances or gestures made by me will result in the immediate termination of the session, and I will be liable for payment of the scheduled appointment.

I have carefully read and understand all of the above and I have answered all questions fully and accurately.

CLIENT SIGNATURE _____DATE_____