Acuity Massage & Advanced Skin Care, LLC
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Massage/Facial Intake form

ALL MEDICAL INFORMATION BELOW IS PROTECTED BY CURRENT COLORADO STATE HIPAA REGULATIONS AND WILL NOT BE SHARED WITH ANYONE WITHOUT YOUR CONSENT

NAME:_____D.O.B._____DATE:_____
ADDRESS _____CITY/STATE_____Zip_____
PHONE#_____CELL_____EMAIL_____
OCCUPATION:_____Does your job require that you work outdoors? YES NO
Marital status: S M D W
Emergency Contact:_____ Relationship_____Phone_____

Were you referred to our office? YES NO If so, by whom:_____
What would you like to achieve from your treatment today?_____
Are you taking any medications/herbs (includes aspirin, ibuprofen, supplements)?
Please list _____
We want to give you the best possible treatment possible. To avoid stimulating or aggravating a current condition we would like to know if you have any chronic systemic illnesses that we should be aware of? (examples: Hepatitis, Epstein Barr, Diabetes, etc.)

_____

Do you have any allergies to medications, lotions, detergents, cleaning products, etc?

_____

We occasionally use aromatherapy or essential oils in our treatments. Do you have any sensitivities to any scents or products that are scented?_____
Have you ever had any injuries or surgeries? Please list occurrence and date: _____

_____

Please mark below a (C) for current conditions and (P) for past conditions:

Headaches/migraines ____ Allergies ____ Neck Pain ____ Back pain _____
Spinal column disorders ____ Sprains/strains _____ Muscle/joint pain _____
Muscle/bone injuries ____ Arthritis/tendonitis ___ Numbness/tingling ____
Heart/circulatory disorders ___ High/Low Blood Pressure___ Blood thinners ___
Diuretics _____ Chronic pain ____ TMJ ____ Varicose/spider veins ____
Diabetes ____ Clotting disorders _____ Cancer/tumors ____ Asthma or Lung Conditions ___
Indigestion/Heartburn/Hernia ___ Constipation/diarrhea ___ Crones disease ____
Thyroid problems ___ Infectious diseases ____ Athletes foot ____
Hearing problems/deafness ____ Depression ____ Anxiety/Stress ____ Menopause ____
PMS _____ Insomnia ____ Sinus problems ____ Pregnancies ____Vision problems or contacts___ Dental bridges, braces ____ Birth Control ____ Skin Conditions____ Acne ____
Rashes ___ Cold sores ____ Rosacea ___ Claustrophobia ___ Light sensitivity (skin or eyes) ___
Other medical conditions not listed: _____

LIFESTYLE

1) How many hours do you sleep per night?_____
2) How often do you exercise?_____
3) On a scale of 1 (low) to 10 (high), how would you rate your stress level?_____

NUTRITION

4) Circle any of the following foods that you consume and indicate how often and approximate quantities:
Sugar:_____Spicy foods:_____Dairy Products:_____
Salty foods:_____Snack foods:_____Meat Products:_____
5) Circle the types of fluids that you consume daily and indicate the quantities:
Water:_____Juices:_____Tea:_____
Coffee:_____Alcohol:_____Sodas:_____
Please list all forms and frequency of stress reduction activities, hobbies, exercise or sports participation: _____

YOUR SKIN CARE

6) Have you ever had a facial treatment before? NO YES, when?_____
7) Have you ever had body spa treatment before? NO YES, when?_____
Massage NO YES Salt Glow NO YES
Seaweed Wrap NO YES Moor Mud NO YES
Body Scrub NO YES
Other:_____

8) Which of the following best describes your skin type. (Please circle ONE type number)

I	*Creamy Complexion never tans*	*Always burns easily,*
II	*Light Complexion slightly*	*Always burns, tans*
III	*Light/Matte Complexion tans gradually*	*Burns moderately,*
IV	*Matte Complexion tans well*	*Seldom burns, always*
V	*Brown Complexion tan*	*Rarely burns, deep*
VI	*Black Complexion pigmented*	*Never burns, deeply*

9) Do you have any special skin problems or concerns pertaining to your face or body? NO YES
Specify:_____
10) Have you ever had chemical peels, laser or microdermabrasion? NO YES
In the last month? NO YES
11) Have you ever had Botox injections or fillers? NO YES
If so, where/when?_____

12) Have you ever had permanent makeup applied? NO YES
*If so, where/when?*_____

*13) Have you ever undergone plastic surgery?*_____
*When?*_____
*Where on your body?*_____
*What information can you provide about the procedure:*_____
*14) Do you use Retin-A, Renova, Adapalene Hydroxyl Acid, or Retinol/Vitamin A derivative products? NO YES Describe:*_____
15) Have you used any of the products below in the last 3 months? NO YES If so, please specify what skin care products you are currently using (List brand where known)

*Soap*_____ *Shower Gels*_____
*Toner*_____ *Body Lotions*_____
*Mask*_____ *Sunscreen*_____
*Eye Product*_____ *SPF*_____
*Cleanser*_____ *Night Moisturizer/Cream*_____
*Day Moisturizer*_____ *Exfoliator*_____
*Scrubs*_____ *Makeup Products*_____
*Other*_____

*16) Have you used an acne medication? NO YES When:*_____
*Which drug:*_____
17) Have you recently used any self tanning lotions, creams or treatments? NO YES
*Specify:*_____
18) Have you used any of the following hair removal methods in the past six weeks? NO YES
Circle all that apply: Shaving Waxing Electrolysis Tweezing Stringing Depilatories
19) What areas of concern do you have regarding your SKIN: (Circle any that apply and explain)

Breakouts/Acne *Uneven skin tone* *Distended capillaries* *Flaky skin*
Blackheads/Whiteheads *Sun damage* *Redness/ruddiness* *Dehydrated*
Excessive oil/shine *Wrinkles/fine lines* *Sun spots/liver spots/ brown spots*
Rosacea *Dull/dry skin* *Other* _____

Eyes: *Dehydrated Wrinkles Puffiness Dark circles Other:*_____
Lips*: Dehydrated Cracked/chapped lips Other:*_____

*20) Have you ever had an allergic reaction to any of the following? Please check any that apply and explain:*_____
Cosmetics *AHA's (Alpha hydroxy acids)* *Medicine* *Fragrance* *Food*
Shellfish *Animals* *Latex* *Sun screens* *Drugs* *Iodine* *Pollen*
*Other:*_____

*21) What SPF do you use on your face?*_____*How often/when?*_____

22) What SPF do you use on your body?_____ How often/when?_____
23) Have you had any recent tanning bed or sun exposure that changed the color of your skin?
No Yes Specify_____

24) Have you experienced Botox, Restylane or Collagen injections? No Yes
Specify:_____
Female Clients Only:
25) Are you taking oral contraceptives? No Yes
Specify:_____
26) Any recent changes to or from your contraception treatment? No Yes
If so, what and when:_____
27) Are you pregnant or trying to become pregnant? No Yes
28) Are you lactating? No Yes
29) Any menopause problems? No Yes
Specify:_____
30) Are you undergoing any hormone replacement therapy? No Yes
Specify:_____

Male Clients Only:
31) What is your current shaving system? Wet shave Electric
32) Do you experience irritation from shaving? No Yes Ingrown hairs? No Yes
33) Are you using any type of hormone replacement therapy? NO Yes
Specify:_____

It is important that you drink plenty of water after a massage and/or facial. Both promote circulation of blood, lymph and in some cases intestinal matter. Water helps clear toxins and keeps you feeling your best. It is recommended that you drink half your body weight, daily, in ounces of water. This does not mean coffee, tea, soft drinks, etc.

Please take a moment and carefully read the following information and sign where indicated.
If you have a specific medical condition or specific symptoms, massage/bodywork/facial may be contraindicated. A referral from your primary care provider may be required prior to services being provided. I understand that the massage/bodywork/facial I receive is provided for the basic purpose of skin care, relaxation and relief of muscular tension. Because massage/bodywork/ facials are contraindicated (should not be done) 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 practitioner updated as to any changes in my medical profile.

Parent or Guardian Signature: _____Date: _____