CONFIDENTIAL

# NATURAL FACE LIFT MASSAGE

## CONSULTATION FORM

## SECTION A - *Complete this section if you are a new customer, or if you have NOT filled out this section on another consultation form previously.*

Name:

Mobile:

Landline:

Email:

Address:

Occupation: *(optional)*

Height: *(optional)* Weight: *(optional)*

DOB: *(optional)* Age: *(optional)*

Do you Smoke? Y ☐ N ☐ Daily Quantity:

Doctor/GP: *(optional)*

GP Tel: *(optional)*

GP Address: *(optional)*

## SECTION B - *Please complete this section*

**What is the reason for your treatment?**

**Presenting Conditions** *(Tick all that apply):*

☐ Jowls ☐ Loose Skin ☐ Toothache ☐ Eye Infection ☐ Eczema ☐ Contagious Skin Disorders

☐ Eyebags ☐ Sagging Neck ☐ Cysts ☐ Inflammation ☐ Psoriasis ☐ High Temperature / Fever

☐ Sagging Skin ☐ Thread Veins ☐ Local Pain ☐ Serious Medical Conditions e.g. Cancer *(please explain below)*:

If you have a serious medical condition or any other health condition not listed above, please explain:

**Skin Type** *(Tick all that apply):*

Dry ☐ Oily ☐ Combination ☐ Sensitive ☐ Ultra Sensitive ☐ Prone to Breakouts ☐ Hormone Reactive ☐

**Skin Issues** - E.g. Dermatitis, Acne, Eczema, Psoriasis, Skin Allergies, Broken Skin, Thread Veins, Skin Infections *(briefly explain):*

**Medical Background** *(Tick all that apply):*

**Muscular System** - including injuries, ache or pain in muscles and joints *(briefly explain):*

Yes ☐ No ☐

**Skeletal System** - including injuries, fractures, arthritis *(briefly explain):*

Yes ☐ No ☐

**Circulatory System** - including heart, angina, thrombosis, varicose veins, fluid retention, family history *(briefly explain):*

Yes ☐ No ☐

**Blood Pressure** - including hypertension, hypotension, medication, stable, unstable *(briefly explain):*

Yes ☐ No ☐

**Lymphatic System** - including swelling in lymph glands, tonsils, adenoids, frequent infection *(briefly explain):*

Yes ☐ No ☐

**Respiratory System** - including bronchitis, asthma, sinusitis, ear infections, cough *(briefly explain):*

Yes ☐ No ☐

**Medical Background Continued** *(Tick all that apply):*

**Nervous System** - including headaches, migraine, tension, stress, anxiety depression *(briefly explain):*

Yes ☐ No ☐

**Cancer** - including diagnosis, date, treatment, medication, prognosis, remission, family history *(briefly explain):*

Yes ☐ No ☐

**Allergic Reactions** - including triggers e.g. medication, supplements, food, additives, beeswax, products *(briefly explain):*

Yes ☐ No ☐

**Diabetes** - including stable, unstable, diet or medically controlled, family history *(briefly explain):*

Yes ☐ No ☐

**Operations** - including dates, locations, scarring *(briefly explain):*

Yes ☐ No ☐

**Medications** - including prescribed, supplements, over the counter *(briefly explain):*

Yes ☐ No ☐

**Do you drink alcohol?** *(If yes, what is your weekly alcohol consumption):*

Yes ☐ No ☐

**Do you exercise?** *(If yes, list types and frequency of excercise)*

Yes ☐ No ☐

**Do you get 6 or more hours of sleep daily?** *(describe pattern, duration, ease of getting to sleep, wake feeling refreshed, disturbed)*

Yes ☐ No ☐

**Are you happy with your diet?** *(describe i.e., regular, reduced, gluten free, vegan, vegetarian, diabetic, dairy free, sugar free, etc.):*

Yes ☐ No ☐

**Do you drink enough fluids?** *(describe your daily fluid intake: Water, Tea, Coffee, Fruit Juice, Other, and quantities of same):*

Yes ☐ No ☐

**Do you get stressed regularly?** *(Rate your stress levels on a scale from 1 – 10 (10 being the highest) and describe frequency:*

Yes ☐ No ☐

**Additional Information:**

## SECTION C - *Complete this section if you are a new customer, or if you have NOT filled out this section on another consultation form previously.*

Please provide us with two contacts in case of an emergency. Thank you.

| | EMERGENCY CONTACT 1 | | EMERGENCY CONTACT 2 |
|---|---|---|---|
| Name: | | Name: | |
| Mobile: | | Mobile: | |
| Town: | | Town: | |
| Relationship to you: | | Relationship to you: | |

## SECTION D - *Please complete this section*

By signing this document, I attest to the truthfulness and completeness of the information provided in this form /consultation, to my therapist regarding my health. I hereby declare that I have not withheld any information that may affect the outcome of the treatment. The treatment has been fully explained and I have been made aware of any possible reactions which could occur. I hereby indemnify therapist, **Denise Coleman** against any adverse reactions that I may feel are sustained as a result of the treatment.

I give permission to this therapist to hold my records: **A )** to best deliver their services ☐ **B)** to confirm appointments ☐ *(Please tick both boxes)*

I acknowledge that typing my name below constitutes my electronic signature and signifies my consent to the terms and conditions outlined above.

**Client Signature:** **Date**:

***Please complete the form and either email it to info@denisecoleman.com or bring a printed copy to your initial appointment. Failure to do so may result in the inability to proceed with treatment.***