Urban Squeeze
massage & facials

FACIAL INTAKE FORM
CONFIDENTIAL INFORMATION

WELCOME! We would like to make your appointment as pleasant and comfortable as possible. If at any time you have questions regarding your session, please let me know.

Name ..... Date of birth .....

Address .....

City ..... State ..... Zip .....

Email ..... Phone .....

Occupation ..... How did you hear about us? Thumbtack Facebook Google
Other: .....

(please circle) (please circle)

Have you ever received massage / skin therapy? Yes* No *If yes, how often? .....

Type(s) of massage or skin therapy experienced: .....

Are you currently taking any medications? Yes* No

*If yes, please list name and reason for medications .....

.....

Are you currently seeing a healthcare professional? Yes* No

*If yes, please list reason/treatment .....

How often do you exercise? daily 1-3 times per week 3-5 times per week
weekly bi-weekly sometimes rarely

Exercise routine, if any? .....

What is your skin type? Oily Dry Normal/Aging Acne Sensitive

IS IT OKAY IF WE USE doTERRA essential oils during your treatment? Yes No

Please review this list and **circle** those conditions that have affected you either recently or in the past.

arthritis
***diabetes**
blood clots
broken/dislocated bones
bruise easily
cancer
chronic pain
constipation/diarrhea
auto-immune condition
hepatitis (A, B, C, other)
aids
open cuts
***allergies**
cough/flu symptoms
varicose veins
headaches
heart conditions
back problems
high blood pressure
insomnia
muscle strain/sprain
currently pregnant
scoliosis
seizures
whiplash/recent car accident
chemical dependency (alcohol, drugs)
respiratory problems
fainting spells/dizziness
***skin conditions**
stroke
***recent surgery**
TMJ disorder/jaw pain
anemia
herniated disks
***neurological problems**
wear contact lenses
wear hearing aids
open cuts
depression/panic disorder/ other psych condition
ulcers
muscle cramping
***injuries/ severe pain**

Please elaborate on the *** selections** (if circled on first page):.....

.....

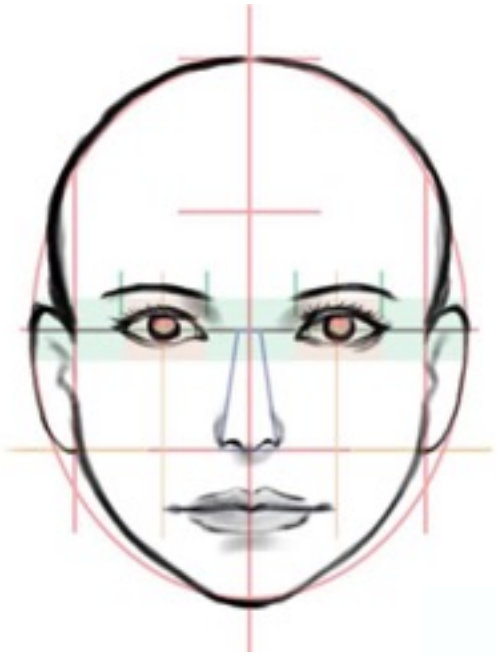
.....

What are your **goals/expectations** for this therapy session?.....

.....

Please mark and label the diagram with OILY, DRY, ACNES,AGING, SUN DAMAGE AND OTHER CONCERNS.

X Oily O Dry //// Acne +++ Wrinkles/Scaring --- Sun Damage



The following sometimes occurs during massage/facials. They are normal responses to relaxation. Trust your body to express what it needs to: ** moving or changing position * sighing, yawning, change in breathing * stomach gurgling emotional feelings and/or expression * memories * energy shifts * falling asleep*

Please read the following information and sign below:

1. I understand that although massage and skin therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis and treatment.
2. This is a therapeutic massage or facial and *any sexual remarks* or advances will terminate the session and I will be liable for payment of the scheduled treatment.
3. Being that massage or facials should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully.
4. I consent to allow Urban Squeeze to email me information about our practice or other general health information.

Signature:..... Date:.....

(If under 18 please have parent/guardian sign)