LuminEssence Facelifting Massage™

Name_____ Phone_____ Age_____

Address_____

What is your occupation?_____ How did you hear about me?_____

Have you had a facial before?_____

Have you had a massage before?_____

Any recent broken bones or fractures?_____

Are you having any issues with (circle) Headache Back Neck Shoulders TMJ

Do you have any allergies? (fruits/nuts)_____

Have you ever had a bad reaction to any face products?_____ if so list_____

Yes	No	
_____	_____	Are you wearing contact lenses? If you think they will bother you please remove them.
_____	_____	Are you pregnant?
_____	_____	Do you have any contagious skin diseases?
_____	_____	Are you presently under the care of a physician or other health professional?
_____	_____	Are you taking any blood thinner medications?
_____	_____	Any sensitivity or allergies to lotions, creams or any oils?
_____	_____	Are you allergic to, or dislike any fragrances?

Do you have any medical conditions not yet mentioned? If so, please explain_____

If there is any information that you think I need to know to be able to give you the best possible treatement, please don't hesitate to tell me. All your questions are very much welcomed.
All information will be kept strictly confidential.
All of the above information is true to my knowledge.

Sign_____ **Date**_____