C

Bellanina® Facelift Massage
CLIENT PROFILE FORM

Name: Last First Date:

Name: _____

Address: _____

Phone: _____ E-Mail: _____

Referred By: _____

Please answer the questions below:

What is your treament goal today? (Check all that apply)

☐ Toning/Tightening ☐ Skin Rejuvenation ☐ Pampering/Relaxing ☐ Symptomatic Relief (headache, jaw, neck)

Please indicate your skin type: (Check all that apply)

☐ Oily ☐ Dry ☐ Blemished ☐ Normal ☐ Sensitive ☐ Combination

Have you ever undergone any facial cosmetic surgery, chemical peel and/or laser treatment? Yes ☐ No ☐

Do you have any knee, hip, foot, arm, neck or joint problems? Yes ☐ No ☐

If yes, explain: _____

Are you currently under a doctor's care for any condition that would be impacted by facelift massage? Yes ☐ No ☐

If yes, explain: _____

Have you seen a doctor in the past year for a skin disorder? Yes ☐ No ☐

If yes, explain: _____

Are you currently taking any prescription drugs for your face? Yes ☐ No ☐

If yes, please list: _____

Are you pregnant? Yes ☐ No ☐

Are you allergic or have you reacted unfavorably to any plant-based ingredients?

If yes, explain: _____

Have you ever had....(check all that apply)

☐ Acne ☐ Eczema ☐ Dermatitis ☐ Seborrhea ☐ Psoriasis ☐ Herpes Simplex

Please tell us about your current skin care regimen:

PRODUCT	USE	BRAND NAME	PRODUCT	USE	BRAND NAME
Cleanser	AM/PM		Exfoliant	AM/PM	
Toner	AM/PM		Masque	AM/PM	
Moisturizer	AM/PM		Sunblock #	AM/PM	
Treatment	AM/PM		Retinoids	AM/PM	
Treatment	AM/PM		Alpha Hydroxy	AM/PM	
Eye Creme	AM/PM		Skin Bleachers	AM/PM	

Are you getting the results you desire from the products you use? Yes ☐ No ☐

Would you be interested in learning about healing and anti aging products to help meet you skin care goals? Yes ☐ No ☐

If you are interested in toning and tightening your face, may I share with you our series approach to facial fitness? Yes ☐ No ☐

PLEASE NOTE: IF YOU ARE WEARING CONTACTS, PLEASE REMOVE THEM BEFORE YOUR THERAPY.