

## Bellanina® Facelift Massage

## CLIENT PROFILE FORM

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 fig. 19.  If yes, explain:  Have you have any knee, hip, foot, arm, neck or joint problems? Yes No fig. 19.  If yes, explain:  Have you seen a doctor in the past year for a skin disorder? Yes No fig. 19.  If yes, explain:  Have you go allergic or have you reacted unfovorably to any plant-based ingredients?  If yes, explain:  Have you ever had(check all that apply)  Acre you allergic or have you reacted unfovorably to any plant-based ingredients?  If yes, explain:  Have you ever had(check all that apply)  Acne Ezezma 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 Sunblack # AM/PM  Toner AM/PM Retinoids AM/PM  Ireatment AM/PM Retinoids AM/PM  Treatment AM/PM Retinoids AM/PM  Ireatment AM/PM Alpho Hydroxy AM/PM	Name:							_
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ye Creme AM/PM Skin Bleachers AM/PM  Are you getting the results you desire from the products you use? Yes No No						AM/PM		

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