TMT
Tru Massage Therapy
Relaxation, Restoration, Recovery

Client Name: _____ Today Date_____

Address: _____

Cell Phone/Work/Home:_____

E-mail:_____Birthday:_____

Name of Physician or Dermatologist? _____

What concerns (if any) do you have about your skin?_____

What skincare products/line are you currently using?_____

What time of the day do you cleanse your skin? _____

How many hours before oil shows? _____Never?_____

Oil in what areas? _____ wide t-zone_____ narrow T-zone _____classic zone_____

We do not sell or give away any personal information. It is for our records only.

SKIN HISTORY & LIFESTYLE

Describe your skin condition?

☐ Sun Damage

☐ Brow/lip lines ☐ deep ☐ fine

☐ Upper lip lines ☐ deep ☐ fine

☐ Freckles

☐ Wrinkles ☐ deep ☐ fine

☐ Blackheads

☐ Whiteheads

☐ Clogged Pores

☐ Hard bumps under skin

☐ Excessive Oiliness

☐ Acne

☐ dry patches

☐ Visible/Exposes Blood vessels

☐ Pimples ☐ Often ☐ Sometimes

Please fill out other side of consent form

Please check if you have the following conditions:

___High Blood Pressure

___ Psoriasis

___ Epilepsy

____ Lupus

____ Cardiac Problems

____ Fever Blisters

____ Pregnancy Mask

____ Metal pins or plates

____ Pacemaker

___ Asthma

___ Eczema

____ Seborrhea

____ Hyper/Hypo pigmentation

___ Sunburn

Please answer the following additional information? (YES or NO)

Do you smoke? _____

Do you consume alcohol?_____

Do you tan? ____ How often?_____

Do you have allergies?_____

Have you ever had a facial surgery? _____ When?_____ Chemical Peels?_____

Have you ever used or currently use:_____ Acutane_____ Retin A_____ Renova_____Botox

Do you currently wax or use depilatories?_____ What areas?_____

Do you have regular periods?_____ Menapause?_____

Are you allergic to Sulphur?_____

Do you take oral medications? Please list: _____

Do you exercise?_____ Do you wear sunscreen?_____

Would you like more information on any of the following services?

_____ ***Waxing*** ____ ***Spray Tan*** ___ ***Hair Services*** ___ ***Manicures*** ___ ***Pedicures*** ____***Massages***

Client Signature _____

ESTHETICIAN CHECKLIST:

Sensitivity ____Yes ____ No

Relaxed Elasticity ____ Yes ____ No

Dehydration ____ Yes ____ No

Pharmagel products used Anti/Aging

____ Blackheads ____ Whiteheads _____Pustules _____ Papules _____ Acne _____ Cysts ____ Rosacea

___Milia _____ Dry Patches _____ Brown Spots ____ White Spots ____ Scars _____ Large Pores ____ Wrinkling

____ Redness ____ Broken Capillaries ____ Sunburn

Esthetician Signature _____