bellanina®
LEARN. BEAUTIFULLY.

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.

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Massage Intake Form

Personal Information

Name _____ Phone (day) _____ (evening) _____

Address _____ City/State/Zip _____ DOB _____

Occupation _____ Employer _____

Email _____ Primary Physician _____

Emergency Contact _____ Relationship _____ Phone _____

How did you hear about us? _____

Medical Information

Are you taking any medications? ☐ yes ☐ no

If yes, please list name and use: _____

_____

Are you currently pregnant? ☐ yes ☐ no

If yes, how far along? _____

Any high risk factors? _____

Do you suffer from chronic pain? ☐ yes ☐ no

If yes, please explain _____

What makes it better? _____

_____

What makes it worse? _____

_____

Have you had any orthopedic injuries? ☐ yes ☐ no

If yes, please list: _____

Please indicate any of the following that apply to you.

- ☐ Cancer
- ☐ Headaches/Migraines
- ☐ Arthritis
- ☐ Diabetes
- ☐ Joint Replacement(s)
- ☐ High/Low Blood Pressure
- ☐ Neuropathy
- ☐ Fibromyalgia
- ☐ Stroke
- ☐ Heart Attack
- ☐ Kidney Dysfunction
- ☐ Blood Clots
- ☐ Numbness
- ☐ Sprains or Strains

Explain any conditions you have marked above:

_____

_____

_____

_____

Massage Information

Have you had a professional massage before? ☐ yes ☐ no

What type of massage are you seeking?

☐ Relaxation ☐ Therapeutic/Deep Tissue

Other _____

What pressure do you prefer?

☐ Light ☐ Medium ☐ Deep

Do you have any allergies or sensitivities? ☐ yes ☐ no

Please explain _____

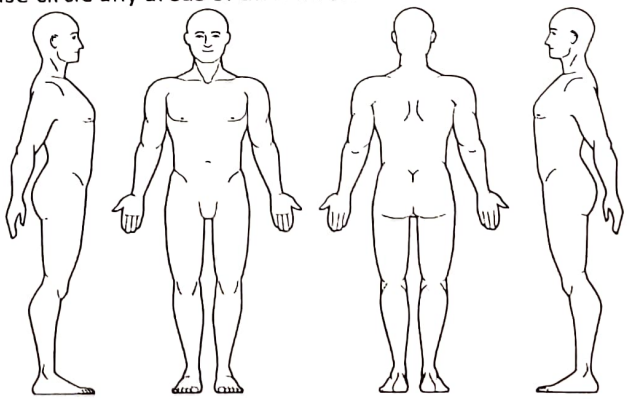
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☐ no

Please explain _____

What are your goals for this treatment session?

_____

Please circle any areas of discomfort



By signing below, you agree to the following.
I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

Client Signature _____ *Date* _____

Therapist Signature _____ *Date* _____

Covid-19 Client Intake Questionnaire

Initial

1. Current Temperature _____°F
2. My temperature has not been above 98.6°F in the past 72 hrs. ____
3. I have not knowingly been in contact with anyone diagnosed with Covid-19 in the past 2 weeks. ____
4. I have not had any of the following symptoms in the past 2 weeks: Fever, Cough, Shortness of Breath, Persistent Chest Pain or Pressure. ____
5. I acknowledge I am receiving Massage Therapy knowing that social distancing cannot be adhered to during my massage session. ____
6. In the event I contract Covid-19, I will notify my therapist as soon as possible. ____

COVID-19 has been declared a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious and is believed to spread mainly from person-to-person contact. As a result, federal, state, and local governments and federal and state health agencies recommend social distancing. Your Massage Therapist has put in place preventative measures to reduce the spread of COVID-19; however, your massage therapist cannot guarantee that you will not become infected with COVID-19. By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that I may be exposed to or infected by COVID-19 by receiving massage therapy and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to myself (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I may experience or incur in connection with my massage therapy appointment. On my behalf I hereby release, covenant not to sue, discharge, and hold harmless my massage therapist, their massage establishment, and any interested parties from the Claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any Claims based on the actions, omissions, or negligence of my massage therapist or the establishment where massage therapy services are received, whether a COVID-19 infection occurs before, during, or after participation in any massage therapy session.

_____ _____

Client Signature Date

_____ _____

LMT Signature Date