



Bellanina® Facelift Massage

CLIENT PROFILE FORM

C

Name: _____

Last _____

First _____

Date: _____

Name: _____

Address: _____

Phone: _____ E-Mail: _____

Referred By: _____

Please answer the questions below:

What is your treatment 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.