# Relax! Massage Therapy & Skin Care

## ***Welcome!***

We are glad you are here, and we look forward to helping you heal and feel your best! We are dedicated to supporting you in reaching your health and wellness goal and will be happy to answer any questions you may have!

## ***PLEASE READ BEFORE SIGNING***
## ***CANCELLATION / NO SHOW POLICY***

It is the policy of Relax! Massage Therapy that we require at least a 24 hour notice for any cancellations or rescheduling. Any same day cancellations or no shows will result in a fee up to the entire service rate and any reschedules will incur a fee.

Please understand that our massage therapists are independent contractors, they are not employees. Compensation for providers is earned at the time of your payment for your appointment. As your time is valuable to you, please value the specific time that has been set aside for your appointment by your provider.

Please call our office to cancel or reschedule your appointment. Leave a detailed message if we are unable to answer and your call will be returned as soon as possible. Thank you for understanding.

By signing this I have read and understand the above.

_____ _____

Signature Date

_____

Printed Name

### ***Covid Consent***

I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted. I understand that I am opting for an elective treatment that may not be urgent or medically necessary, and that I have the option to defer my treatment to a later date. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time.

Signed: _____ Date: _____

### ***MAIL PERMISSION***

**Yes, I would like to receive Thank You Cards and a yearly Birthday Coupon from Relax! Massage Therapy at my address listed**. The return address label will have the name of the business on the envelope. We promise not to send ***any*** junk mail!

Signed: _____ Date: _____

**PLEASE TURN OVER AND COMPLETE OTHER SIDE**

JANMARINI SKIN RESEARCH®

# Skin & Health Questionnaire

Please answer the following questions thoroughly and completely, as this provides a better understanding of your general health, lifestyle and skin care concerns; thereby enabling the best skin care program to be customized for your individual needs.

**Name:** _____ **DOB:** _____

**Address:** _____

**Occupation:** _____ **Email:** _____

**Cell Phone:** _____ **Alternative Phone:** _____

**Let us thank the person who referred you**_____

## Skin Care History

**If there was something you could change or improve about your skin, what would it be?**

_____

**What else? Please check all that apply:**

- ○ Discoloration (Brown Spots or Melasma)
- ○ Fine Lines & Wrinkles
- ○ Dry, Flaky Skin
- ○ Oily Skin
- ○ Acne/Breakouts
- ○ Acne Scarring
- ○ Enlarged Pores
- ○ Rosacea
- ○ Dilated Capillaries
- ○ Redness (Reactive Skin)
- ○ Uneven Texture
- ○ Sun Damage
- ○ Loss of Facial Contours
- ○ Lax or Sagging Skin
- ○ Dark Under-Eye Circles

**What type of skin do you think you have?**

_____Dry _____ Normal _____Combination _____Oily

If oily, are you oily throughout the cheek area? Yes_____ No_____

**Do you have a history of acne?** Yes_____ No_____

**If yes, are you using or have you ever used any medications for acne?** Yes_____ No_____

**Name of medication**_____

**Do you sunbathe or participate in outdoor activities?** Yes_____ No_____

**Have you ever had a reaction to any skin care product or cosmetic?** Yes_____ No_____

**If yes, please list**_____

**What skin care do you currently use?**

| Morning | Evening |
|---|---|
| 1) | 1) |
| 2) | 2) |
| 3) | 3) |
| 4) | 4) |
| 5) | 5) |

**Please check if you are currently using or have used any of the following:**

- o Retinol
- o Glycolic Acid
- o Lactic Acid
- o Salicylic Acid
- o Citric Acid
- o Resorcinol
- o Benzoyl Peroxide (BPO)
- o Hydroquinone
- o Tretinoin (Retin A™, Renova™, Refisa™)
- o Topical Antibiotics
- o Topical Steroids
- o Adapalene (Differin™)
- o Azelaic Acid (Azelex™, Finacea™)
- o Isotretinoin (Accutane™)

**Have you ever, or, are you currently receiving skin services?** Yes_____ No_____

**If yes, what services**_____

**Have you had any of the following?**

- o Chemical Peels
- o Laser Resurfacing
- o Facial Cosmetic Surgery
- o Facial Injectibles
- o Permanent Cosmetics
- o Light Treatments
- o Microdermabrasion
- o Dermaplanning
- o Extractions
- o Electrolysis
- o Laser Hair Removal
- o Waxing

## General Health

**Are you currently under the care of a physician?** Yes_____ No____

**If yes, please discuss contraindications of any pre-existing medical conditions with your physician.**

**Are you currently taking any medications?** Yes_____ No_____

**If yes, please list here**_____

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SKIN RESEARCH®

**Female Clients**

**Are you on hormone – replacement therapy?** Yes_____ No_____

**Are you currently taking birth control pills?** Yes_____ No_____

**Are you pregnant or breast feeding?** Yes_____ No_____

**Please check the following conditions you have, or have had, in the service area:**

- o Dermatitis
- o Eczema
- o Psoriasis
- o Open Sores or Lesions
- o Cold Sores/ Fever Blisters
- o Actinic Keratosis
- o Keloid Scarring

**Are you allergic to aspirin?** Yes_____ No_____

**If you have any known allergies, please list them:**

_____

**Is there anything else that should be known before starting your services?**

_____

_____

_____ _____

Signature Date