SALUS Massage Therapy
HEALTH • WELL-BEING

Facial Intake Form

Name: _____ Date of Birth: _____

Address: _____ Phone: _____

_____ Occupation: _____

- **Have you ever had a facial? Y N**
  If yes, what did you like/dislike about your experience?

- **How would you describe your skin? Circle all that apply:**

Dry	Sensitive	Oily
Flaky	Redness	Discoloration
Fine Lines	Acne	Combination
Wrinkles	Dull	Large Pores
Normal	Blackheads	Lack of Firmness

Out of the above selected, what is your primary concern for your skin?

- **What products/brands do you currently use on your skin?**

- **Are you currently under the care of a dermatologist? Y N**
  If Yes, describe any conditions/treatment:

***Specifically, note medications and medicated skin products that have been prescribed (ie RetinA/retinol products, Differin, Accutane, etc):**

- **Do you use any over-the-counter products for your skin that contain other active ingredients such as Benzoyl peroxide, salicylic acid, AHA, glycolic acid, etc? Please note:**

- **Do you have sensitive skin or any allergies? Y N**
  Type:

- **Please circle any conditions that apply to you:**

Hypertension	Diabetes	HIV
Psoriasis	Herpes	Hepatitis
Ringworm	Pink Eye	Skin cancer

Please note any other general health conditions, or recent surgeries or injuries below:

- **Please list any other medications you are currently taking:**

- **Are you pregnant? Y N**

Waxing Information

What areas are you interested in having waxed?

Eyebrows Upper Lip Chin

Note any facial hair removal concerns/sensitivities:

Have you had these areas waxed previously?

Are you pregnant?

This area for practitioner use

Signature:_____ Date:_____