

FACIAL REFLEXOLOGY/FACELIFT MASSAGE

Consultation Form

Client's Name	
Gender	
Date Of Birth	
Address	
Phone	
Email	
Treatment Date	
Treatment Number	

How can Facial Reflexology/Facelift Massage help you today? (Remember this could be beauty- and/or health-related)

How is your current state of health? (Recent surgery, facial surgery, whiplash, pre-existing illnesses, diseases, disorders, accidents, injuries, operations, allergies, Headaches/Insomnia, Stress/Mood swings, Bowel movements/Constipation/Indigestion/Diarrhoea, Thyroid condition/Diabetes, Pregnancy etc) Please note any presenting conditions.

Contra-indications (Please note that therapists must follow their professional protocols for identifying contra-indications, and act according to those protocols.)

Please also follow the Facial Reflexology/Facelift Massage training you have received regarding clients with any of the following:

Facelift	Botox	Facial Fillers
Cold Sores/Acne Boils	Epilepsy/Neurological Conditions	Facial surgery (including dental surgery)
Arthritis	Whiplash	Pregnancy

Are you on any medication? (current)

Do you suffer any side effects as a result of taking this medication?

Do you have any allergies/reactions, including to any facial products or essential oils?

LIFESTYLE

What is your normal diet? (typical daily intake, fluids & supplements)

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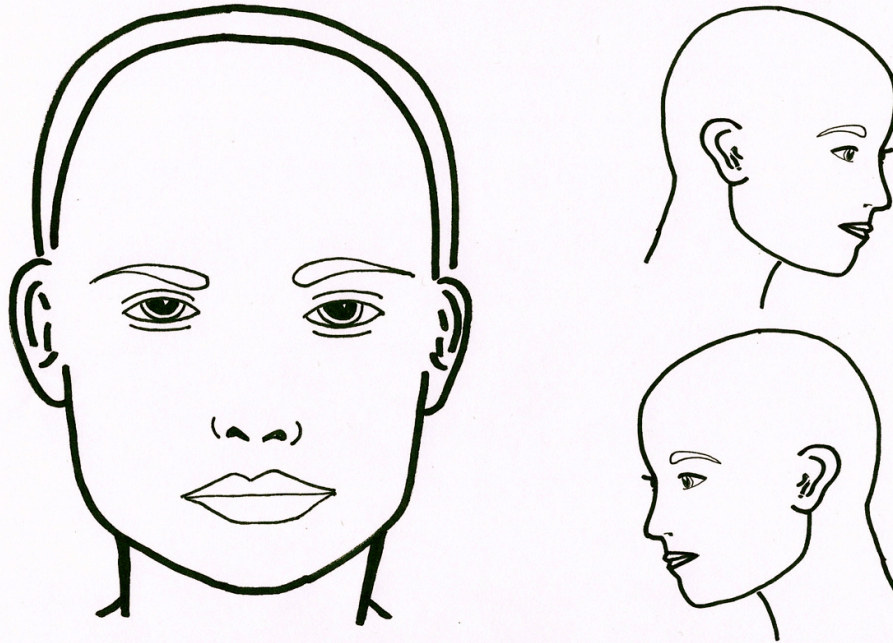
Do you normally take any exercise?

Do you smoke? (if so, how much)

Do you normally consume alcohol?: (if so, how much and how often)

Stress Levels/Worries and Fears (on a scale of 0 to 10, where 0 is "no worry")

Follow our Facial Reflexology and Facelift Massage protocol, letting the client know how you will be adapting your treatment, and give the client a practical outcome to the treatment (eg, sleeping better/less stress etc.). Afterwards, mark your observations on the face chart.



Aftercare advice given to the client after the treatment: (list TWO new holistic lifestyle suggestions that the client could implement between treatments)

I have not withheld any information regarding my health and the information I have provided is true to the best of my knowledge. I consent to this treatment. I have been informed of contra-indications.

Client Signature:

Date:

Therapist's Signature:

Date: