Dear Client:
To assist us in providing you with the proper skin care, we would appreciate your taking a few moments to fill out this comprehensive skin analysis record. It will aid in keeping a closer watch on the progress and improvement of your skin.

NAME: _____ DATE OF BIRTH: _____ OCCUPATION: _____
ADDRESS:_____ CITY: _____ ZIP: _____
PHONE: (Home) _____ (Work/Cell) _____ e-mail Address _____

How did you hear of us? ☐ Internet ☐ Friend ☐ Other _____
Have you ever had skin care /professional massage treatments before? ☐ Yes ☐ No
When?_____ Skin Cancer - Type _____
Have you seen a dermatologist/medical doctor/chiropractor? ☐ Yes ☐ No Are you under treatment now? ☐ Yes ☐ No
Do you or have you had eczema/Seborrhea/psoriasis? ☐ Yes ☐ No Have you had cosmetic surgery? ☐ Yes ☐ No
Do you take birth control pills/Vitamins/Medication/Hormones Are you pregnant/nursing ? ☐ Yes ☐ No

Have you had deep skin peeling? ☐ Yes_____ ☐ No List any allergies _____
Have you ever suffered from acne? ☐ Yes ☐ No ☐ Heavy ☐ Light ☐ Other
Have you ever had a reaction form any skin care products or cosmetic? ☐ Yes ☐ No _____
Do you wear a pacemaker or have metal implants? ☐ Yes ☐ No What type of pressure do you prefer ☐ light ☐ Medium ☐ Firm
Do you use Accutane, Retin A, Renova, Adapalene or any other prescription skin products? ☐ Yes ☐ No ☐ in the last 3 months
Are you currently using any products that contain the following ingredients? ☐ Glycolic acid ☐Lactic acid ☐ any exfoliating scrub
☐ any hydroxy acid product ☐ Vitamin A derivatives (i.e. retinal)

SKIN ANALYSIS

1. Pigmentation: ☐ Even ☐ Uneven ☐ Strong Stains ☐ Birth Marks ☐ Suntanned
2. Muscle Tone: ☐ Good ☐ Fair ☐ Fallen Other _____
3. Neck Condition: ☐ Baby wrinkles ☐ Skin to loose ☐ Wrinkles ☐ Double chin ☐ Turkey neck
4.

ISLANDTOUCH MASSAGE & SPA
969 S. Federal Highway , Stuart, FL 34994
Tele/Fax: (772) 286-8699 www.islandtouchmassage.com
Lic. #36721 MM #13235

Couperose/Broken Caps: ☐ Nose ☐ Cheek ☐ Chin ☐ Forehead ☐ Neck ☐ Whole face and neck

5. BASIC SKIN TYPE & TREATMENTS
Oily Skin _____
Acne/Blemished Skin _____
Combination Skin ☐ T-Zone ☐ Dry Combination ☐ Oily Combination ☐ Other
Dry Skin _____ Mature Skin _____
Sensitive & Allergenic skin _____
6. Other Conditions of the skin or health related _____

SKIN CARE RECOMMENDATIONS

Cleanser _____ Glycolic Acids _____
Freshener/Astringent _____ LED Light therapy_____
Moisturizer(s) Day _____ Night _____ Microdermabrasion
_____
Masks _____ Telangitron/Spider Veins_____

MASSAGE THERAPY

Do you have spinal problems? ☐ Yes ☐ No Which area? _____ Are you diabetic/asthmatic/claustrophobic ? ☐ Yes ☐ No
Do you have any cardiac or circulatory problems ? ☐ Yes ☐ No Do you suffer for any seizures? ☐ Yes ☐ No
Do you have high blood pressure? Are you taking Medication for it? ☐ Yes ☐ No Do you have arthritis or osteoporosis ? ☐ Yes ☐ No
Do you have distended capillaries or varicose veins? ☐ Yes ☐ No Where _____
Do you have blood clots or bruise easily? Do you take blood thinners ? ☐ Yes ☐ No Have you suffered any acute injury? ☐ Yes ☐ No
Do you have pain that radiates down the arms and legs? ☐ Yes ☐ No Have you ever had cancer or being treated for it now? ☐Yes ☐No

Signature: _____
Date: _____

A typical full body massage for one hour will include back, arms, legs, feet, hands, shoulders, neck and head and scalp. The massage will not include genital areas (male or female) or breasts. A half hour massage will only allow for a partial massage session, such as neck and shoulders or legs and feet, or full back area.

I affirm that I have stated all known medical conditions, and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's or Establishment's part
should I fail to do so.

Signature: _____
Date: _____