

Buccal Face Massage

Client Intake Form

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| Full Name: |  | | Age: | |  |
| Mobile: |  | | | | |
| For women: are you pregnant?  (if YES – how many weeks?) | |  | | | |
| Known allergies: (please list) | |  | | | |
| Please list any medications, supplements or alternative remedies you are taking that may affect the session: | |  | | | |
| Are you comfortable with having intraoral (buccal) procedure? (i.e., practitioner working inside the oral cavity wearing sterile gloves? | | | | YES / NO | |

Treatment History

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| Have you had any facial aesthetic procedures done in the last 6 months? (e.g., chemical peels, injections, fillers, threads etc.). If YES, please list the type of procedure/s and date/s: |
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| Have you had plastic surgery? If YES, please list the type of procedure/s and date/s: |
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| Have you had a buccal massage before? If YES, were there any complications or comments you would like to make about the experience? |
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Contraindications & Risks

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| ABSOLUTE (tick as applicable) | RELATIVE (tick as applicable) |
| Systemic contagious or infectious diseases, including the common cold, flu and COVID and 7 days after | Nervous or psychotic conditions |
| COVID vaccination – 14 days after | Excessive emotional excitability |
| Acute conditions requiring first aid or medical attention | Mild rosacea |
| Acute pain anywhere in the body | Pregnancy II trimester |
| Severe unstable hypertension | Post-cancer or cancer in remission |
| Fever | Allergies of various aetiology |
| Nose bleeding | Spinal disk hernias, bulging, thinning or degenerative discs (especially in the neck) |
| Under the influence of drugs or alcohol, including prescription pain medication | Clients of 60+ years of age and/or with known conditions affecting bone health (osteoporosis, osteopenia etc.) |
| Recent operations including plastic surgery or acute injuries | Managed thyroid conditions |
| Benign tumors and various cancers | Botox – not earlier than 5 weeks post injection |
| Serious nervous or psychotic conditions | Fillers – not earlier than 12 weeks post injection |
| Epilepsy | Mesothreads and threadlifting – not earlier than 3 months post procedure |
| Heart problems, angina, those with pacemakers |  |
| Herpes in acute stage | Please provide details for any selected conditions: |
| Bleeding of the gums, mouth ulcers |  |
| Pregnancy I and III trimester |
| Unmanaged thyroid dysfunction |
| Autoimmune thyroid dysfunction |
| Pathologies of lymphatic system including inflammation of lymphatic nodes |
| Damaged lymphatic vessels |
| Acute rosacea and couperose, skin inflammation |
| Open cuts and wounds, and local inflammation of the skin |
| Psoriasis, neurodermitis, eczema |
| Sunburn |

Medical History

Do you have any of the below chronic conditions – check any that apply

CARDIO-VASCULAR SYSTEM (ANGINA, ARRHYTHMIA, PACEMAKER, ARTERIAL HYPERTENSION, HIGH BLOOD PRESSURE, VARICOSE VEINS)

KIDNEY (STONES, RENAL FAILURE)

LIVER (GALLSTONE DISEASE, HEPATITIS)

GASTROINTESTINAL (STOMACH OR DIGESTIVE COMPLAINTS)

PULMONARY (ASTHMA)

NERVOUS SYSTEM (EPILEPSY; HERNIATED, BULGING DISCS; NEURALGIA; BELLS’ PALSY; RAMSEY HUNT SYNDROME; INFLAMMATION OF TRIGEMINAL / FACIAL NERVE; STROKE; LOSS OF BALANCE)

MUSCULOSKELETAL SYSTEM (SCOLIOSIS, ARTHRITIS, OSTEOARTHRITIS)

ENDOCRINE SYSTEM (ACUTE THIREOIDTIS, NODULAR GOITER, CYSTS AND/OR GROWING THYROID NODULES, DIABETES)

CHRONICAL ENT DISEASE (EAR, NOSE, AND THROAT)

FAINTING

CANCER / ONCOLOGY REMISSION DATE: / /   
 CLEARANCE LETTER FROM DOCTOR: YES / NO

DENTAL CONDITIONS (PULPITIS, STOMATITIS, PARADONTOSIS, MOUTH ULCERS, DENTAL IMPLANTS, BRACKETS)

MAXILLOFACIAL INJURES

Skin History

Please describe your skin – check any that apply to you

Normal  Mature / Aged  Deep lines

Dry  Eczema / Psoriasis  Relaxed elasticity

Dehydrated  Lifeless  Superficial lines

Oily  Dermatitis  Dilated capillaries

Combination  Saggy / loss of tone  Discolourations

Sensitive  Warts / moles  Photoaging

Wrinkles  Scars  Photoaging

Milium  Couperose  Asphyxiated   
 (whiteheads) (broken capillaries) (blocked pores/follicles)

Comedone  Blemishes / acne  Other …………………   
(blackheads) How many years?  
 Vulgaris YES / NO

Cystic YES / NO  
 Chronic YES / NO

Rosacea YES / NO

Intentions

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| What are your main intention/s for receiving a buccal face massage or what do you hope to experience from it? (e.g., specific aesthetic desires, relaxation and self-care, jaw release, TMJ/grinding/headaches/other health reason) |
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Focus Areas

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| Are there any areas of the face/upper body that you would like to receive more focus? |
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Client Waiver

Please read carefully and sign:

1. I have stated all my known conditions and have answered all questions honestly. I take it upon myself to keep the Practitioner updated on my health.
2. I understand that the Practitioner does not diagnose, prevent or treat illness, disease or any other physical or mental conditions.
3. I understand that this treatment is not a substitute for medical treatments and/or diagnosis, and it is recommended that I see a qualified professional for any physical or mental condition that I may have.
4. The Practitioner has provided and explained the safety issues surrounding my treatment plan. I have had the opportunity to ask any questions.
5. I indemnify and hold Rachel Frost harmless for any injuries or negative effects I may experience as a result of having the treatments done on me or using the products I receive during this consultation.
6. If you are receiving treatment for aesthetic intentions: I consent to be photographed or videotaped before and after treatment for assessment purposes and to track my progress. I understand that these images or videos will be stored securely, and I have the right to assess, modify, or remove any parts of my personal data at any time.

Full Name:  
  
Client Signature:

Date: / /