

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: / /