Client Name:

Buccal Facial Massage

Please take a few moments to fill out this questionnaire carefully. All answers will be held strictly confidential. If you have any questions, please feel free to ask.

First Name: _____ Last Name: _____ Age: _____ Address: _____ City: _____ Postal Code:_____ Home Phone: (_____)_____ Work Phone: (_____) _____
Email: _____ Date of Birth: Occupation:_____ _____
Family Physician: _____ Phone No.: (_____) _____
Address: _____ City: _____ Postal Code:
How did you find us? _____ Referred by: _____

If your goals are for Facial Beauty and Sculpting, please fill out this section:

List any Cosmetic Procedures, Injections, Fillers or Laser Resurfacing that you've recently had or do you use any topical prescription medications at home:

_____
_____
_____

Current Beauty Routine/History:

Cleanser _____ Toner _____ Moisturizer _____ Mask_____

Please check what conditions you hope to improve with Buccal Facial Sculpting Massage:

Wrinkles around Mouth		Sagging		Bags under Eyes	
Deep Wrinkles Nasolabial Fold		Dull Completion		Swollen Eyelids	
Puffy & Swollen Face		Sagging Jowls		Dark Eye Circles	

What Are Your Goals/Expectations For Treatment:

_____
_____
_____

Please describe below the concerns you have about your face and/or skin in order of importance to you:
1. _____
2. _____
3. _____

Please draw lines or circles in the areas you wish to improve:

If your goals are for Facial Health and Pain Reduction, please fill out this section:

Please check what conditions you hope to improve :

TMJ Pain		Chronic Sinus Pain		Overall Facial Edema	
Teeth Clenching		Sinus Congestion		Water retention in Jaw Area	
Teeth Grinding at night		Swollen Eye Area		Other	

What Are Your Goals/Expectations For Treatment:

_____

_____

_____

Please describe below the health concerns you have about your face in order of importance to you:

1. _____
2. _____
3. _____

Please draw lines or circles in the areas you wish to improve:

Informed Consent for Buccal Facial Sculpting Massage

I hereby request and consent to the performance of **Buccal Facial Massage** by **Maureen "Hannah" Maher.** I confirm that the above information that I have provided is correct and as up to date as possible. I agree that if I suspect I have any communicable infection including sinus infections, cold symptoms, sore throat, I will inform Maureen immediately to reschedule my appointment and I will not be subject to last minute cancellation fees due to health reasons"

Cancellation Policy

Please give mininum 24 – 48 hours notice if you need to change your appointment. We reserve the right to charge the 50% deposit fee for less then 24 hours cancellations and missed appointments ("no shows".) Also, clients who repeatedly cancel and request to reschedule previously booked appointments will be asked to contact us the same to day to inquire regarding any availability instead of booking in advance and their access to our online scheduler will be denied. The above policies exist to ensure that all of our clients respect our time and ability to remain organized and offer our best at all times.

Please sign below indicating that you have read the policy and agree to its terms.

Client's Name

_____

Signature_____**Date Signed** _____