



Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

Email \_\_\_\_\_ Phone \_\_\_\_\_

How did you hear of LoveBella? \_\_\_\_\_ What words did you use to search? \_\_\_\_\_

Did you read any reviews? \_\_\_\_\_

Age Group under 20, 20-30, 30-40, 40-50, 50+

Level of Stress on a scale of 1-4 (1=low 4=high Stress) \_\_\_\_\_

Where do you work? \_\_\_\_\_ Occupation \_\_\_\_\_

Are you under the care of a physician for specific health issue? Please explain. \_\_\_\_\_

Please list medications you are currently taking \_\_\_\_\_

Have you ever been seen by a dermatologist? Yes \_\_\_ No \_\_\_ When? \_\_\_\_\_

If yes, for what reason? \_\_\_\_\_

Have you ever had Resurfacing \_\_\_ Micro-dermabrasion \_\_\_ Chemical Peel \_\_\_ Accutane \_\_\_?

Do you consider your skin to be Oily\_\_\_ Dry\_\_\_ Dehydrated \_\_\_ Acne Prone \_\_\_ Sensitive \_\_\_?

Does your skin ever feel obvious dryness \_\_\_ tightness \_\_\_ flakiness \_\_\_?

Do you feel oily or shiny during the day? Yes\_\_\_ No\_\_\_ Occasionally \_\_\_

Do you have a tendency toward redness? Yes\_\_\_ No\_\_\_

Do you have breakouts? Yes\_\_\_ No\_\_\_ Occasionally \_\_\_

Do you currently use Cleanser / Soap / Exfoliant / Scrub / Eye Product / Masque / Moisturizer /  
Brushes / Wash Cloth/ other? \_\_\_\_\_

What product line or products do you use on your face and body? \_\_\_\_\_

Do you use any kind of (please circle) Retin A, Renova, Glycolic Acid, Hydroxy Acid, Lactic Acid

What SPF do you use on your face or body? \_\_\_\_\_

Have you ever had an allergic reaction to anything? Yes\_\_\_ No\_\_\_ Please explain \_\_\_\_\_

Have you ever had any burning or itching on your skin or face? Yes\_\_\_ No\_\_\_ Please explain;  
\_\_\_\_\_

Have you ever had a reaction to Cosmetic, Medicine, Iodine, Pollen, Food, Animal, Fragrance, Sunscreen, other? \_\_\_\_\_

Do you have a history of fever blisters, or cold sores? Yes\_\_\_ No\_\_\_

Do you have any neck or back issues for me to be aware of during massage? Yes\_\_\_ No\_\_\_

Please explain\_\_\_\_\_

Your preferred massage pressure Light / Medium / Firm

Do you like essential oils or know of any that you do not like or are sensitive to? \_\_\_\_\_

Are you pregnant or planning on becoming pregnant? Yes\_\_\_ No\_\_\_

Are you Lactating Yes\_\_\_ No\_\_\_

Would you like extractions today if necessary? Yes\_\_\_ No\_\_\_

Is your pain threshold Low / Med / High?

What are your skin care goals? \_\_\_\_\_

What do you want most from today's appointment? \_\_\_\_\_

***I confirm (to the best of my knowledge) that the answers given are correct and that I have not withheld any information that may be relevant to my treatment.***

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

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Date \_\_\_\_\_ Notes \_\_\_\_\_

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