Massage 4 Life by Kimberly Alvarado

Buccal Massage Addendum (Must Accompany Intake Form)

Name: _____ Date: _____

Contraindications that we need to discuss prior to your appointment:

- ☐ Any contraindications that are on the Initial Intake Form
- ☐ Active Cold Sores
- ☐ HIstory of Cold Sores
- ☐ Recent injuries or surgeries to the face, scalp, teeth, oral region or neck (some examples include: dental work, infections, cuts, etc.)
- ☐ Recent skin treatments (tattoos, microblading, laser treatments, high level exfoliation, or other treatments that make the skin more sensitive)
- ☐ Recent facial hair removal
- ☐ Botox or fillers less than 6 weeks ago
- ☐ Threads or fillers less than 6 months ago
- ☐ Cosmetic surgeries regardless of the date (need surgeon's approval)
- ☐ Pregnant or trying to conceive
- ☐ Cancer
- ☐ Epilepsy
- ☐ Acne (active or prone to)
- ☐ Thyroid Conditions
- ☐ Any skin irritation or sensitivity needed to be discussed

Explain any contraindications below:

Please initial the permissions that you give below. The massage can be done outside the mouth if that is your preference.

I give permission for intra-oral massage. _____

I give permission for intra-auricular massage. _____

I understand that I should inform my therapist if any part of the session becomes too uncomfortable. I understand that I should ask questions at any time if I do not understand what I am experiencing or why. I understand that the therapist is not an esthetician and cannot cleanse or moisturize my face. It is my responsibility to arrive at my appointments with my face freshly washed. My appointment time will not be extended to accommodate my washing my face. I understand that results are not guaranteed. I understand that it is recommended to have sessions no more than 10 days apart for the first 6 sessions. Monthly sessions are then recommended for maintenance. I understand that any exercises given are suggestions and that massage therapists cannot prescribe exercise. I understand that I may experience soreness post-massage.

Name: _____ Date: _____

Therapist: _____ Date: _____

—----------To be filled out at the time of session—----------

The following contraindications were discussed:

These modifications were made:

We agree to this plan on _____and will modify it as needed.

Client: Therapist: