



Esthetics Skillbook

BODY ASSESSMENT (WOMEN)

Date _____

Name _____ Type of Massage _____

Skin Type Normal ☐ Dry ☐ Oily ☐ Combination ☐
Skin Texture Thin ☐ Medium ☐ Thick ☐
Moisture Level Lowest ☐ Low ☐ Medium ☐ High ☐ Highest ☐

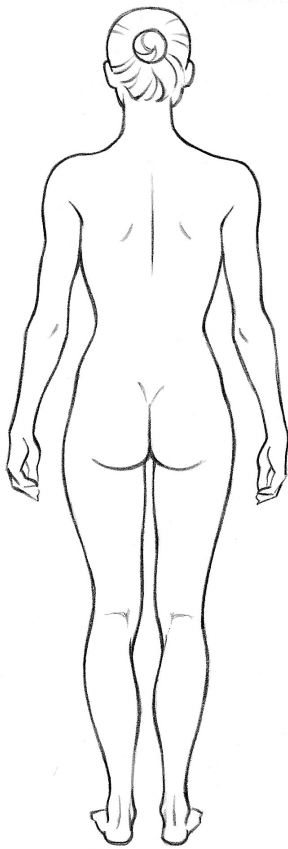
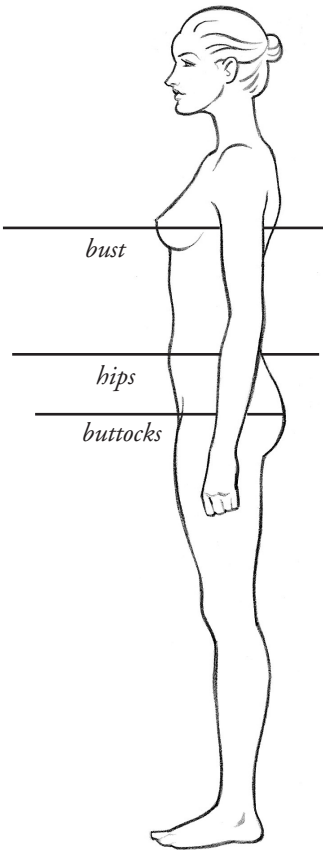
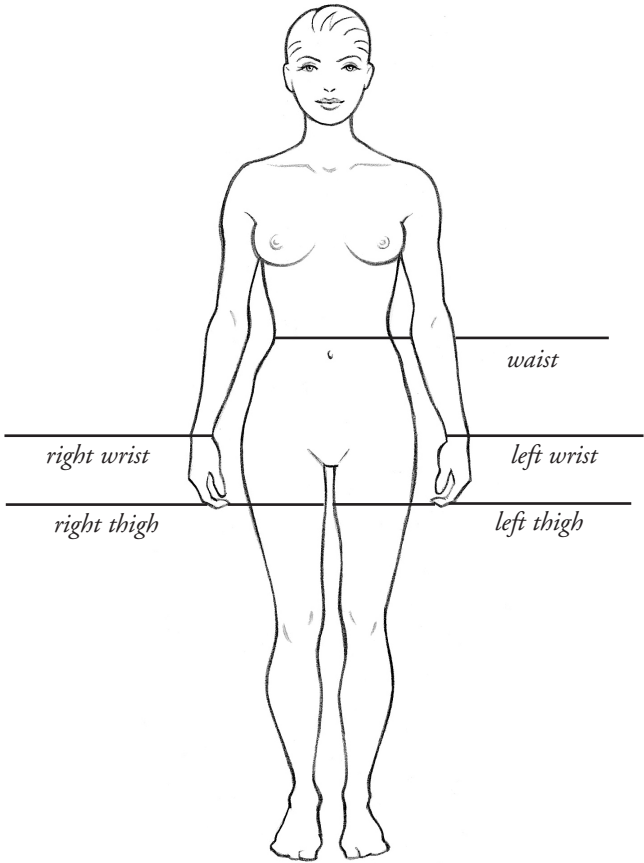
LESIONS (Wood’s Lamp and/or Dermascope)

Macule ☐	Scale ☐	Plaque ☐	Spider Veins ☐
Vesicle ☐	Moles ☐	Fissure ☐	Telangiectasia ☐
Wheal ☐	Papule ☐	Haemangioma ☐	Comedone: ☐
Crust ☐	Pustule ☐	Hypertrophy Scars ☐	Open ☐
Keloids ☐	Erythema ☐	Tumor ☐	Closed ☐
Lichenification ☐	Excoriation ☐	Cyst ☐	Other ☐
Patch ☐	Warts ☐	Milia ☐	_____
Bulla ☐	Nodule ☐	Fibroma ☐	_____

OTHER CONDITIONS, DISEASES AND DISORDERS

Deep Vein Thrombosis ☐	Numbness ☐	High Blood Pressure ☐	Systemic Infection ☐
Thrombophlebitis ☐	Headaches ☐	Mesh Surgery Repair ☐	Varicose Veins ☐
Recent Cancer ☐	Osteoporosis ☐	Recent Scarring ☐	Adult Acne ☐
Hemophilia ☐	Fasciitis/Tendonitis ☐	Skin Disorders (<i>open sores, abrasions, infections, psoriasis inflammation</i>) ☐	Ulcer ☐
Uncontrolled HBP ☐	Bone Fractures ☐	Easily Bruised Skin ☐	Diabetes ☐
Multiple Sclerosis ☐	Heart Pacemaker ☐	Spider Veins ☐	Any other short-term or chronic illness/condition ☐
Lymphedema ☐	Diagnosed Heart Condition ☐	Surgical Procedures ☐	Other ☐
Arthritis ☐	Circulatory Problems ☐		_____
Asthma ☐	Hernia ☐		

MEASUREMENTS AND INDICATIONS Draw any posture faults and skin disorders, including moles, warts, bruises, dilated capillaries, varicose veins, etc. Use key to indicate Fat (///), Cellulite (xxx), Poor Muscle Tone (---) and Stretch Marks (ooo). List all measurements on the line provided.



©2002 L. Saphonia Gee

I understand that massage therapy is for relaxation and relief of muscle tension. If I experience any discomfort, I will inform the therapist immediately. I understand that my massage therapist is not qualified to perform skeletal adjustments or diagnose/prescribe/treat any physical or mental illness and that I should consult a physician or other qualified medical professional for any ailment of which I am aware. Because massage should not be performed under certain medical conditions, I affirm that I have answered all questions to the best of my knowledge. I further understand that the information herein is to aid the therapist in giving the most appropriate and safe treatment available and remains confidential.

Patient Signature _____ Date _____

Consent of treatment of Minor/Dependent to administer massage: Parent/Guardian _____ Date _____