WAXING TREATMENT

Consultation Form

CLIENT INFORMATION

Name: _____ Date: _____

Date of birth: _____ Age: _____ ☐ Female ☐ Male ☐ NB

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Emergency contact: _____ Phone #: _____

Would you like to be added to our email list for news and exclusive offers? *Yes* ☐ *No* ☐

MEDICAL HISTORY

Do you have or have you had any of the following conditions? If yes, please select them:

- ☐ Aids/HIV
- ☐ Eczema/Psoriasis
- ☐ Cold sores/Fever Blisters
- ☐ Hepatitis
- ☐ Herpes
- ☐ Varicose Veins
- ☐ Cancer
- ☐ Diabetes
- ☐ Other skin irritation

Have you ever been treated for cancer? ☐ No ☐ Yes

If yes, when and what types of therapies were used?

_____

Any known allergies? ☐ No ☐ Yes: _____

List any medications you take regularly, including vitamins, herbal supplements, aspirin:

_____

Any other illness/condition: _____

♀ When is your next menstrual cycle due to begin? _____

(Always allow five days for menstrual cycle. Because of water retention and for your own personal comfort, you should avoid hair removal two days before your cycle is due and two days after it is completed.)

Are you pregnant? ☐ No ☐ Yes

SKIN HISTORY

Do you have any tendencies to:

☐ Ingrown hair ☐ Scarring ☐ Bumps ☐ Bruising ☐ Hyperpigmentation

Have you used any Alpha Hydroxy Acid (AHA) or glycolic products in the past 72 hours? ☐ No ☐ Yes

Are you using Retin-a, Renova or Accutane? ☐ No ☐ Yes

Are you using any other skin thinning products and/or drugs? ☐ No ☐ Yes

Are you exposed to the sun on a daily basis? ☐ No ☐ Yes

Do you plan to spend more time in the sun soon? ☐ No ☐ Yes

Do you use a tanning bed? ☐ No ☐ Yes

Have you ever had a waxing treatment before? ☐ No ☐ Yes

Have you ever had a reaction to waxing? ☐ No ☐ Yes

What skin products do you regularly use on your skin? _____

WHAT SERVICE WOULD YOU LIKE:

Face:

- ☐ Brow
- ☐ Lip
- ☐ Chin
- ☐ Full face
- ☐ Side bums

Upper body:

- ☐ Full arms
- ☐ Half arms
- ☐ Under arms
- ☐ Back/shoulder
- ☐ Abdomen
- ☐ Chest

Lower body:

- ☐ Full legs
- ☐ Half legs

Other:

- ☐ Brazilian
- ☐ Bikini
- ☐ Full body
- ☐ Other: _____

By signing below, you agree to the following:

I have completed this form truthfully and to the best of my knowledge. I agree to inform the technician of any changes in the above information. I agree to waive all liabilities toward my technician and the employer for any injury or damages incurred due to any misrepresentation of my health history.

_____	_____	_____
Client Name (printed)	*Client Name (signature)*	*Date*

_____	_____
Esthetician (signature)	*Date*