Waxing Treatment

CONSULTATION FORM

CLIENT INFORMATION

Name: _____ Date: _____

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

Phone: _____ Email: _____

Emergency Contact: _____ Phone Number: _____

How did you hear about us? _____

MEDICAL HISTORY

Please note any health conditions you may currently have: _____

Please list any known allergies: _____

List any medications you take regularly: _____

List any recent surgeries or skin treatments: _____

SKIN HISTORY

Have you ever been waxed before? YES/NO

Are you Retinol, Retin-a, Renova, Differin, Tretinoin or Accutane? YES/NO

Are you using any other skin-thinning products and/ or drugs? YES/NO

Is your skin prone to ingrown hairs, bumps or bruising? YES/NO

Have you ever had a reaction to waxing? YES/NO

Are you pregnant? YES/NO

Are you mensurating? YES/NO

Are you taking antibiotics? YES/NO

Is your skin currently sunburned? YES/NO

By signing below, you agree to the following:

I have completed this form truthfully and to the best of my knowledge. I agree to waive all liabilities toward my technician and the employer for any injury or damages incurred due to any falsification of my medical history

_____ _____

Client Name (Printed) Client Name (signature)

_____

Date