

CONFIDENTIAL CLIENT INTAKE FORM FOR WAXING

General Information

Name _____ Birthday _____
Address _____
City _____ State _____ Zip/Postal Code _____
Phone # _____ Email _____
Occupation _____
Emergency Contact Name _____ Phone # _____
Would you like to be added to our email list for specials and discounts? Yes No
How did you hear about us? _____

Service(s) Being Performed

Face & Brows

Brow Shape
Lip
Chin
Full Face
Sideburns

Upper Body

Full Arms
Half Arms
Underarms
Back/Shoulder
Abdomen
Chest

Lower Body

Full Legs
Half Legs

Other

Brazilian
Bikini
Full Body
Other: _____

Medical History

Please check all that apply:

Acne
Fever Blisters
Hepatitis
HIV
Skin Cancer
Psoriasis
Shingles
Warts

Diabetes
Heart Condition
Herpes
Low Blood Pressure
Surgery: _____
Rashes
Skin Cancer
Other: _____

Eczema
Hemophiliac
High Blood Pressure
Lupus
Pregnant
Seborrhea
Hyper/Hypo Thyroid

Have you ever been treated for cancer? Yes No
If yes, when and what types of therapies were used? _____

Are you currently taking any medications? Yes No
If yes, please list: _____

Do you have any allergies? Yes No
If yes, please explain: _____

Skin Care History

Please list any skin care products that you currently use: _____

Have you used any AHA products in the last 72 hours? Yes No

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

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

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

Do you currently have a sunburn? Yes No

Do you plan on spending more time in the sun soon? Yes No

Have you recently used a tanning bed? Yes No

Have you recently had a chemical or glycolic peel? Yes No

Have you waxed before? Yes No

If yes, when? _____

If yes, did you have any adverse reactions? Yes No

If yes, please explain: _____

Do you have any abrasions, moles, or skin irritations in the areas being waxed today?

Yes No

If yes, explain: _____

(Female clients) When is your next menstrual cycle due to begin? _____

(For your own comfort, we recommend avoiding hair removal from two days before to two days after your cycle.)

By signing below, I agree to the following:

I have completed this form to the best of my ability and knowledge. I agree that I do not have any condition(s) that would make the requested treatment unsuitable. I agree to waive all liability toward my technician and the salon for any injury or damages incurred due to any misrepresentation of my health.

Name Printed

Signature

Date

Esthetician Name Printed

Signature

Date
