



WAXING CONSULTATION FORM

GENERAL INFORMATION

Full name: _____ Date of birth: _____

Address: _____

Phone: _____ Email: _____

Emergency contact name: _____ Phone: _____

What is your gender? Male Female Non-binary Other

Are you 18 years of age or over? Yes No

How did you hear about us? _____

MEDICAL HISTORY

Do you currently or have a history of any of the following medical conditions:

- Scleroderma
- Epilepsy
- HIV positive
- Rashes
- Eczema
- Keloid scarring
- Warts
- Varicose veins
- MRSA
- Blisters/cold sores
- Forehead/brow lift
- Dermatitis
- Bleeding disorders
- Sunburn
- Shingles
- Skin cancer
- Haemophilia
- Skin conditions
- Chemotherapy/radiation
- Heart condition
- Thyroid issues
- Diabetes
- Hepatitis (A,B,C,D)
- Other

If 'Other', please detail: _____

Do you have any known allergies? Yes No

If 'Yes', please detail: _____

List any medications you are currently taking (e.g. Accutane, Retin-A, Renova):

Do you take any skin thinning medications? Yes No

Have you ever been treated for cancer?

Notes: _____



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(continued)

SKIN HISTORY

Skin Type:

- Ingrown hair
- Scarring
- Bumps
- Bruising
- Hyperpigmentation

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

Have you used any Alpha Hydroxy Acid (AHA) or glycolic products in the past 48-72 hours? Yes No

Are you using Rein-a, Renova, Differin, Tazorac 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 use a tanning bed? Yes No

Have you ever had a waxing treatment before? Yes No

Have you ever had a reaction to waxing? Yes No

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

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 currently pregnant? Yes No

What areas are we waxing today?

Face:

- Brow
- Lip
- Chin
- Full face
- Side burns

Upper Body:

- Full arms
- Half arms
- Under arms
- Back/shoulders
- Abdomen
- Chest

Lower Body:

- Full legs
- Half legs

Other:

- Brazilian
- Bikini
- Full body
- Other: _____

CLIENT NAME (PRINTED)

CLIENT NAME (SIGNATURE):

DATE: