



CLIENT INFORMATION/MEDICAL HISTORY

Name _____ Age _____ Date _____

Address _____ City _____ State _____ Zip _____

Email Address _____

Cell _____ Date of Birth _____

Emergency Contact _____ Relationship _____ Cell _____

Medications (Prescriptions/over the counter med, vitamins, herbal medications)

Drug Allergies _____

Major Surgeries/Facial surgeries _____

Ongoing facial treatments? (Injectibles/Laser/chemical peels/waxing/facials) _____

Please circle if you have any of the following conditions –

Heart Disease Excessive Bleeding High Blood Pressure Hepatitis Skin Cancer Liver Disease

Lupus Auto-Immune Disorders Diabetes Neuromuscular Disease Cold Sores/Fever Blisters

Lidocaine allergy/sensitivity

Pregnant? Y N Breastfeeding? Y N

The above information is true and accurate to the best of my knowledge.

Client Signature

Date

WAXING

CONSENT FORM

I _____ give my
consent to receive waxing treatments.

Are you affected by or have any of the following?

- | | |
|--|--|
| <input type="checkbox"/> Pregnant/Lactating | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Tanning by Booth or Sun | <input type="checkbox"/> Recent Chemical Peels |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Eczema/Psoriasis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Immune Disorders |
| <input type="checkbox"/> Rosacea | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Skin Cancer | <input type="checkbox"/> Excessive Telangiectasias |
| <input type="checkbox"/> Cold Sores/Herpes | <input type="checkbox"/> Hemophilia/Blood Thinners |

Other Medical Conditions _____

Current Medications _____

By signing below, you agree to the following:

I understand that results will vary between individuals and no guarantees have been made regarding my personal results. I understand that my results may be compromised if I do not follow the aftercare instructions that I have been given.

I understand that if I am using or begin to use any products or medications listed on this page it is my responsibility to inform the technician prior to this treatment and all future treatments.

I have been informed of and understand the contraindications to the requested treatments and agree that I do not have any condition(s) and I am not using any products that would make the requested treatment unsuitable. I will inform the technician of any discomfort I may experience at any time during my treatment to allow them to adjust accordingly.

The procedure and side effects have been explained to me and I have had the opportunity to ask questions. My questions have been answered in a satisfactory manner.

I agree to waive all liabilities toward my technician and the employer for any injury or damages incurred. I accept all risk and liability for this cosmetic procedure. This consent form is valid for future treatments until it is rescinded by me in writing.

Client Signature (Guardian if under 18)

Date _____

[wăks-ing] verb

the process of hair removal from the root by using a substance to adhere to body hair, and then removing this substance which pulls the hair out from the follicle.

In the last 14 days, I have NOT used any of the following:

Retin A	Azelaic Acid
Altinic	Tazarotene
Renova	Retinol
Avage	Differin
Tretinoin	Retin-A
Vitamin A Derivative Products	

initial _____

I have NOT used Alpha-Hydroxy Acid, Glycolic Acid, Salicylic Acid, Hydroquinone, or over the counter steroid creams in the last 48 hours.

initial _____

I have NOT taken Accutane in the past 12 months.

initial _____

I have NOT used Prednisone, topical or oral steroids, topical or oral antibiotics in the last 14 days.

initial _____

I understand that the following are potential side effects:

Redness	Bumps
Irritation	Bruising
Breakouts	Skin Lifting
Ingrown Hairs	Sun Sensitivity
Infection	Bleeding