# Confidential
## *Waxing Client Intake Form*

## General Information

Name | Date of Birth

Address

City | State | Zip 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**
- ☐ Brows
- ☐ Lip
- ☐ Chin
- ☐ Full Face
- ☐ Side Burns

**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 | ☐ Arthritis | ☐ Depression |
| ☐ Diabetes | ☐ Eczema | ☐ Epilepsy |
| ☐ Fever Blisters | ☐ Heart Condition | ☐ Hepatitis |
| ☐ High Blood Pressure | ☐ HIV | ☐ Hyper Pigmentation |
| ☐ Hypo Pigmentation | ☐ Insomia | ☐ Low Blood Pressure |
| ☐ Lupus | ☐ Sinus Infection | ☐ Surgery: |
| ☐ Pregnant | ☐ Psoriasis | ☐ Rashes |
| ☐ Seborrhea | ☐ Shingles | ☐ Skin Cancer |
| ☐ Hype/Hypo Thyroid | ☐ Warts | ☐ Other: ___________ |

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:

| Question | Yes | No |
|---|---|---|
| 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, please 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 to inform the technician of any changes in the above information. I agree that I do not have any condition(s) 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. 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 |