WAX CONSULTATION FORM

Today's Date ____________________

Name____ Birthday ______/______/__________

Address____________________________________ City_____________ State______ Zip_________

Phone (______) _______-__________ Best way to remind you of your appt: CALL / TEXT / EMAIL

Email ____

How did you hear about us? AD / INT / REF NAME: ____________________________________

What body part are we waxing today?_________________________________Design? ______________

When did you last shave or trim? _____________Have you been waxed before? YES / NO When? __________

Do you have any tendencies towards:

Ingrown hair YES / NO
Break outs YES / NO
Bumps YES / NO

Hyperpigmentation YES / NO
Bruising YES / NO
Scarring YES / NO

Eczema YES / NO
Psoriasis YES / NO

Are you currently using or taking:

Isotretinoin/Accutane YES / NO
Retin-A YES / NO
Alpha-hydroxy Acid YES / NO

Resorcinol YES / NO
Glycolic Acid YES / NO
Any Scrubs or Peels YES / NO

Indoor Tanning YES / NO
Self Tanners YES / NO

Medical Data

Herpes Virus YES / NO

Staph/MRSA YES / NO

Allergies YES / NO

List: ____

Other information ____

Waxing may cause: Bruises, scabs, scarring, redness, hyperpigmentation, pimples or a flare up of any of the above mentioned conditions/responses. Waxing of soft tissue may cause the skin to tear resulting in the need for stitches. (Most common occurrence is in Brazilian Bikini waxes, male or female.) ________

I understand that if I have Herpes or Staph/MRSA, I may experience an outbreak after the waxing service. The professional has explained the best way to minimize or prevent an outbreak when waxing regularly. _________

I understand I may carry Herpes and/or Staph/MRSA without any physical symptoms or a medical diagnosis. I also understand that the waxing service does not allow the opportunity to contract these conditions from my technician. _________

I understand all of the above mentioned reactions. I also understand if I change my skin care routine or medications I must inform the professional PRIOR to any service in the future. ________

I understand that I must be showered and prepared for my service. ________

CC# for file: _____-_____-_____-_____ Exp: ___/___ CVN:____ Billing:________________________Zip:_______
I understand that if I cancel or miss my appointment within the 24 hour cancellation policy I will be charged $25.00 or HALF of the service fee, whichever is greater.

____
Print Name

____
Authorizing Signature **Date**

____
Print Name

____
Technician Signature **Date**