CLIENT INTAKE & HEALTH HISTORY for WAXING

Name: _____ Date: _____

Address: _____

Cell Phone: _____ Date of Birth: _____

Email: _____

Emergency Contact: _____ Emergency Number: _____

Have you ever had waxing done before? ☐ YES ☐ NO

If yes, how frequently do you have waxing done? _____

Have you ever had a reaction to a waxing service? ☐ YES ☐ NO

If yes, please describe: _____

Have you been or will you be in the sun and/or tanning bed within 24 hours ? ☐ YES ☐ NO

List any allergies:

Have you used the following in the last 7 days? ☐ YES ☐ NO

- AHA/Alpha-Hydroxy Acid
- BHA/Beta-Hydroxy Acid
- Retiniods
- Hydroquinone for Skin Lightening

Do you have any allergies? If yes, use list on the side ☐ YES ☐ NO

Have you had the following treatments in the last 4 weeks? ☐ YES ☐ NO

- Microdermabrasion
- Laser Surfacing
- IPL Therapy
- Injectable Treatments (Botox or Dermal Fillers)

Have you used the following in the last year? ☐ YES ☐ NO

- Accutane
- Roaccutane
- Tetracycline or Isotretinoin

Are you undergoing Radiation and/or Chemotherapy? ☐ YES ☐ NO

List any other concerns? _____

I am aware that it is my duty to submit truthful information. ◯ I agree to the terms of service

Client Signature_____ Date_____

Update every 6 mos.

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