WAXING FORM

Today's Date_____

Name_____Birthday_____/_____/_____

Address_____

Phone_____ Email_____

What service are we doing today?_____ Have you been wax before?_____

Do you have any tendencies toward?

Ingrown hair Y/N

Hyperpigmentation Y/N

Eczema Y/N

Break outs Y/N

Bruising Y/N

Psoriasis Y/N

Bumps Y/N

Scarring Y/N

Are you currently using or taking?

Accutane Y/N

Resorcinol Y/N

Indoor Tanning Y/N

Retin A Y/N

Glycolic Acid Y/N

Self-Tanners Y/N

Alpha-hydroxy Acid Y/N

Scrubs or Peels Y/N

Waxing may cause: Bruises, scabs, scarring, redness, hyperpigmentation, pimples or a flare up of any of the above mentioned conditions/responses. _____

I understand that if I have any STD's I may experience an outbreak after the waxing service.

_____

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 if I cancel or miss my appointment within the 24 hour cancellation policy I will be charged for the service or if I have a package I will lose one of my services.

_____ _____

Client

Esthetician