Wax Consultation Form

Name :________________________________ Date of Birth :______________________
Street: ______________________________ City: ____________ Zip:_____________
Home phone:________________________ Cell Phone: ___________________________
Email: _____________________________ Occupation:__________________________

Have you ever been waxed before? YES NO
Have you had any of these health problems past or present?
____Cancer ____Heart Problems _____Varicose Veins
____Diabetes ____Blood Pressure _____Hormone Imbalance
____Epilepsy _____Thyroid _____Loss of Sensation

Are you taking any medications for any of the above problems? YES NO
Are you using any of the following prescription medications?
____Retin A _____Antibiotics _____Hydrocortisone
____Renova _____Adaptalene _____Heart Medications

Are you currently under physicians or dermatologists care? YES NO
If YES, please state condition & any medications:_______________________________
____
Are you pregnant? YES NO Are you due or having menstrual cycle? YES NO

Are you undergoing any of the following procedures?
_____Chemical Peel If YES, what type: ______________________
_____Laser Treatment If YES, what type: _______________________
_____Facial Surgery
_____Dermabrasion
Have you had any of the above treatments in the last three months? YES NO
Have you had any excessive sun in the last 48 hours? YES NO

Are you currently using any skin care products that contain the following?
____Glycolic Acid ____Lactic Acid ____Exfoliating Scrubs _____Hydroxyl Acids

During/after waxing have you experienced: Severe Redness, Blistering or Skin lifting? ______
Do you have Reactions after waxing? YES NO

I confirm to the best of my knowledge that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment.

Signature:__________________________ Date:________________

Therapist Signature: _____________________ Date:________________