



## Waxing Consultation Form

Client Name:	Phone Number:
Address:	Cell Number:
Please indicate: <input type="checkbox"/> Male <input type="checkbox"/> Female	Email:

### General Health History

Please check if you have experienced any of the following (Y-Yes, N-No). Please give details where necessary.

	Y	N	Provide Details
Do you have any skin condition:	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have any allergies?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you taking or using any medications (Prescription/OTC)	<input type="checkbox"/>	<input type="checkbox"/>	
Are you taking any antibiotics?	<input type="checkbox"/>	<input type="checkbox"/>	(NOTE: The use of antibiotics can also make one more sensitive to waxing.)
Have you ever used Accutane?	<input type="checkbox"/>	<input type="checkbox"/>	How long?
Are you prone to cold sores?	<input type="checkbox"/>	<input type="checkbox"/>	(Also known as herpes virus.)
What skin care products are you currently using?	Circle all that apply		Cleanser    Toner    Exfoliant    Mask    Moisturizer/Lotions Comment
Do you use any products that contain the following:	Circle all that apply		Retin-A    Renova    Differin    Glycolic Acid/AHA    Salicylic Acid    Topical Cortisone Comment
Have you ever had:	Circle all that apply		Laser Treatments    Chemical Peels Comment
Do you have?	Circle all that apply		Diabetes    Asthma    Arthritis    Hemophilia    Cancer    High Blood Pressure    Heart Disease Comment
Have you been in a tanning bed within the last 48 hours?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever had any adverse reactions to waxing?	<input type="checkbox"/>	<input type="checkbox"/>	Please explain:
Menstruation and birth control medication will often make an individual more sensitive to many types of hair removal.			
Are you menstruating or within one week of menstruating?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you on birth control?	<input type="checkbox"/>	<input type="checkbox"/>	

### Aftercare and Recommendations

Please check the following to ensure you understand these recommendations.

	Y	N
Apply a sunblock with an SPF of at least 15 daily	<input type="checkbox"/>	<input type="checkbox"/>
Avoid use of loofah or other abrasives to the waxed area (within 24 hours)	<input type="checkbox"/>	<input type="checkbox"/>
Avoid sauna, steam room, whirlpool bath or other heat source (for 24 hours)	<input type="checkbox"/>	<input type="checkbox"/>
Avoid application of Retin-A, AHA product or other exfoliant product for 48 hours before and after waxing	<input type="checkbox"/>	<input type="checkbox"/>
Avoid all irritating chemicals such as chlorine pools, perfumes, fabric softeners, deodorants (for 24 hours)	<input type="checkbox"/>	<input type="checkbox"/>

### Contraindications/Cautionary Conditions

The following is a list of contraindications to waxing services which will make this waxing appointment inadvisable or may result in certain body areas not being waxed. Your Esthetician will review these with you prior to your treatment.

Please check if you have any of the following (Y- Yes, N- No). Please give details where necessary.

	Y	N	
Broken Skin, Open cuts, Pustules or Papules	<input type="checkbox"/>	<input type="checkbox"/>	Practitioner's Comments
Inflammation	<input type="checkbox"/>	<input type="checkbox"/>	
Bruises	<input type="checkbox"/>	<input type="checkbox"/>	
Sunburn	<input type="checkbox"/>	<input type="checkbox"/>	
Rosacea/Very Sensitive Skin	<input type="checkbox"/>	<input type="checkbox"/>	
Recent Chemical Peeling	<input type="checkbox"/>	<input type="checkbox"/>	
Recent Botox/Collagen Injections	<input type="checkbox"/>	<input type="checkbox"/>	
Cosmetic/Reconstructive Surgery	<input type="checkbox"/>	<input type="checkbox"/>	
Suspicious Growths/Moles	<input type="checkbox"/>	<input type="checkbox"/>	
Phlebitis/Swelling - Lower Legs	<input type="checkbox"/>	<input type="checkbox"/>	
Fragile Capillaries/Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	
Flat Moles	<input type="checkbox"/>	<input type="checkbox"/>	
Blood Thinning Medications	<input type="checkbox"/>	<input type="checkbox"/>	

Additional Comments to be noted by Esthetician:

### Acknowledgement

The hair removal procedure and after care have been thoroughly explained to me and I have had the opportunity to ask questions and receive satisfactory answers. I understand that because of certain health conditions, epilation services may not be advised. I also understand that there may be swelling or irritation in waxed areas and that this may only be a temporary condition.

Customer Signature:

Date:

Esthetician Name:

Date:

### Client Follow-up Appointment Review

2nd Esthetician's Name (Print):	Date Reviewed:	Waxing Area(s) & Esthetician Comments/Observations:	Client Initials:
3rd Esthetician's Name (Print):	Date Reviewed:	Waxing Area(s) & Esthetician Comments/Observations:	Client Initials:
4th Esthetician's Name (Print):	Date Reviewed:	Waxing Area(s) & Esthetician Comments/Observations:	Client Initials:
5th Esthetician's Name (Print):	Date Reviewed:	Waxing Area(s) & Esthetician Comments/Observations:	Client Initials:
6th Esthetician's Name (Print):	Date Reviewed:	Waxing Area(s) & Esthetician Comments/Observations:	Client Initials:
7th Esthetician's Name (Print):	Date Reviewed:	Waxing Area(s) & Esthetician Comments/Observations:	Client Initials:
8th Esthetician's Name (Print):	Date Reviewed:	Waxing Area(s) & Esthetician Comments/Observations:	Client Initials: