

## Skincare & Waxing Consent Form

Name \_\_\_\_\_ Cell \_\_\_\_\_

Address \_\_\_\_\_

Email \_\_\_\_\_ DOB \_\_\_\_\_

Have you ever been waxed before? Yes No

What areas are we waxing today? \_\_\_\_\_

Date of last wax? \_\_\_\_\_

How do you normally maintain the area that we are waxing today? \_\_\_\_\_

Have you ever had an adverse reaction to hair removal treatments? Yes No \_\_\_\_\_

Do you regularly use pre/post home care for hair removal? Yes No please describe \_\_\_\_\_

Have you ever had an allergic/adverse reaction to a skin care treatment, product, or ingredient? \_\_\_\_\_

Do you have any known allergies? \_\_\_\_\_

Have you tanned in the last 24 hours? UV or natural sun- Yes No

Have you had any cosmetic/medical surgeries in the last 12 months? Yes No please describe \_\_\_\_\_

Have you had any cosmetic fillers, peels, or laser treatments in the last 12 months? Yes No \_\_\_\_\_

Have you ever had skin cancer, MRSA, staph, herpes cold sores, or skin infections? \_\_\_\_\_

Please list any medical conditions you are currently under a doctor's care for: \_\_\_\_\_

Are you diabetic? Yes No

Please list any prescriptions, supplements, or over the counter medications you are taking: \_\_\_\_\_

Are you currently taking any oral or topical anti aging, anti acne medications or antibiotics? Such as:  
Retin-A Accutane Renova Differin Tazorac Alpha Hydroxy  
Acids (Glycolic, Lactic, or Salicylic Acid) Other:/Please describes: \_\_\_\_\_

What skin care products do you use regularly on your face? \_\_\_\_\_

What is your biggest concern about your scheduled treatment today? \_\_\_\_\_

On a scale of 1-5, 1 being the worst and 5 being not so bad, please rate what you feel your level of sensitivity/reactivity is to waxing : \_\_\_\_\_

I confirm that the information given above is correct, and that to my knowledge, I have not withheld any information that may be deemed relevant to the treatment I am receiving. I acknowledge that there are potential risks and complications to receiving any procedure, and I take responsibility for any side effects should they occur. I am over the age of 18, and I consent to the hair removal treatment with the understanding that it is an elective procedure, no medical claims are expressed, and no results are guaranteed.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date