Therapist: _____
Time: _____

# WAXING CONSENT & CLIENT INTAKE FORM

Name: _____ Phone: (_____) _____

D.O.B: _____/_____/_____ Street Address: _____

City: _____ State: _____ Zip: _____ Email: _____

Emergency contact: _____ Phone: (_____) _____

Occupation: _____ How did you hear about us? _____

*What body part(s) are we waxing today?* _____

*When did you last shave?* _____ *When is your menstrual cycle's start date?* _____

****Because of water retention and for your personal comfort, avoid hair removal two days before your cycle starts and two days after.*

*Do you have or prone to any of the following: (please mark all that apply)*

_____*Ingrown Hairs* _____*Scarring* _____*Bumps*

_____ *Hyperpigmentation* _____*Bruising* _____ *Allergies*

****If yes, please list:* _____

*Are you diabetic?* ____ *Yes* ____ *No*

*Have you ever been treated for cancer?* ____ *Yes* ____ *No*

*Have you used any of the following in the last 48-72 hours? (please mark all that apply)*

_____*Accutane* _____*Glycolic Acid* _____*Scrub or Peel*

_____ *Retin-A* _____*Resorcinol* _____ *Alpha-Hydroxy Acid*

*Have you used other skin thinning medications?* ____ *Yes* ____ *No*

*If yes, please list:* _____

*Do you use a tanning bed?* ____ *Yes* ____ *No*

*Any other illness/condition a medical professional is presently treating you for?* _____

***New use of any of the medications listed above increases the possibility of a reaction. Please inform the esthetician if you have begun taking any new medications since your last session.**

***Please note waxing does have certain side effects such as skin removal, redness, scabbing, bruising, scaring, swelling, tenderness, hyperpigmentation, and/or pimples.**

***Waxing of soft tissue may cause the skin to tear resulting in the need for stitches. The most common occurrence of this is in a Brazilian bikini wax.**

I have read the above information and if I had any concerns, I have addressed them with my esthetician. I give permission to my therapist to perform the waxing procedure we have discussed and will hold her harmless from any liability that may result from this treatment. I have given an accurate account of the questions asked above including

all known allergies or prescription drugs or products I am currently ingesting or using topically. I understand my esthetician will take every precaution to minimize or eliminate negative reactions.

I have read and understand the post-treatment home care instructions. I am willing to follow the recommendations made by my esthetician for a home care regimen that can minimize or eliminate possible negative reactions. In the event that I may have additional questions or concerns regarding my treatment or suggested home product/post-treatment care, I will consult my esthetician immediately.

I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read and fully understand the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered. I understand the procedure and accept the risks. I do not hold the esthetician, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this skin care procedure, which may be affected by the treatment performed today.

_____ _____

**Client Signature** **Date**

_____ _____

**Therapist Signature** **Date**