Waxing Client Intake Form

Date _____ DOB _____
Name: _____
Address: _____
City: _____ State:_____ ZIP:_____
Best Contact Number: _____
Email: _____
Occupation: _____
Referred by: _____

	Yes	No
Is this your first waxing service		

Do you experience any of the following:

Ingrown Hairs		
Scarring		
Herpes Virus		
Cold Sores		
Fever Blisters		
Hyperpigmentation		
Excessively Dry Skin		
Bruising		

Do you have allergies? ( ) Yes ( ) No (if yes list) _____
Do you shave? ( ) Yes ( ) No If so, how often? _____

Are You currently using any Topicals or Oral Medications or ointments?

Topical/Oral	Yes	No	If yes, how Long?	Why?
Accutane				
Retin_A				
Alpha Hydroxy /Glycolic Acids				
Resorcinol				
Retinol				
Renova				
Scrub/Peel of any kind				
Blood Thinners				
Prednisone				

Please List any Medications: _____

Are you currently being treated for cancer or have you had cancer in the past? ( ) Yes ( ) No Please Explain:
_____

Please Note: Waxing *may* cause: bruising, scabs, scarring, redness, hyper-pigmentation or pimples. If you have herpes virus, waxing may activate a breakout. Answering these questions truthfully will help your esthetician in providing the safest possible waxing treatment. Your signature below confirms that you have read and truthfully answered the above questions.

CLIENT SIGNATURE DATE