Waxing Consultation and Informed 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 :_____

Waxing may cause side effects such as but not limited to:

Breakouts	Lifting	
Bumps	Tearing	
Ingrown Hairs	Flares of skin conditions (Herpes cold sores, eczema, psoriasis)	
Redness	Allergic reactions	
Hyperpigmentation	Skin removal	Swelling

Please initial and sign below.

_____I acknowledge that side effects can occur and I fully accept the risk. I understand my Esthetician, Jennifer Clark, will take every precaution to minimize or eliminate negative reactions as much as possible. I will consult my Esthetician first should I have any complications after receiving a wax treatment. I have been given the opportunity to ask questions and any questions have been answered to my satisfaction.

_____I acknowledge that pre & post-treatment care of skin can greatly reduce the pain associated with waxing. Regularly scheduled waxing, exfoliation, and pre-treatment will help to reduce the amount of time it takes to perform hair removal by eliminating dead skin build up. Post care will keep hair growth on track . We use and recommend pre and post treatment for quick, optimal and long lasting results from your waxing service.

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

_____ _____

Esthetician Signature Date

Treatment Notes: _____