



Waxing Questionnaire & Consultation Form

Name: _____

Date of Birth: _____

Address: _____

Telephone: _____

Email: _____

Referred By: _____

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

When did you last shave? _____

When is your menstrual cycle's start date? _____

***Because water retention and for your personal comfort, avoid hair removal three days before and after your cycle starts/ends.**

Do you have or are prone to?

Ingrown Hairs Yes No

Scarring Yes No

Bumps Yes No

Hyperpigmentation Yes No

Bruising Yes No

Allergies Yes No

If Yes, what to? _____

Are you diabetic? Yes No

Pregnant? Yes No

Have you used any of the following in the past 48 - 72 hours?

Accutane Yes No

Retin-A Yes No

Alpha-hydroxy Acid Yes No

Glycolic Acid Yes No

Resorcinol Yes No

Scrub or Peel Yes No

Have you used other skin thinning medications? If so, which?

Do you use a tanning bed? Yes No

Any other illness/condition you are presently being treated for by a medical professional? _____

***New use of any medications listed above increases the possibility of a reaction. Please inform the esthetician if you have begun taking any medications that you know it might have a side effect on your waxing.**

***Please note waxing does have certain side effects such as skin removal, redness, scabbing, bruising, scarring, 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 the 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 procedure, which may be affected by the treatment performed today.

Client Signature: _____

Date: _____

Esthetician Signature: _____