Waxing Questionnaire & Consent Form

Name _____ D/O/B _____

Address _____

Mobile Phone _____ Home Phone _____

Email _____

How did you hear about us? _____

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

When did you last shave? _____How often do you shave? _____

Occupation _____

Circle Your Answers To The Questions Below

Medical: MRSA Herpes AIDS HPV Allergies

** If I have Herpes or MRSA I may experience an outbreak.*

Do you have or are you 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
Have you ever been treated for cancer?	Yes	No

Have you used any of the following in the last 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 skin thinning medications?	Yes	No

If so, which? _____

Do you use a tanning bed?	Yes	No

List all illnesses and/or conditions you are presently being treated for by a medical professional.

_____

_____

_____

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.

***Ladies**: During menstrual cycle - Because of water retention and for your comfort, avoid hair removal two days before your cycle starts and two days after.*

New use of any of the medications listed on the previous page increases the possibility of a reaction. Please inform your Technician if you have begun taking any new medications since your last session.

I give permission to my Therapist to perform the waxing procedure we have discussed. I have given an accurate account of the questions asked above including all known allergies, prescription drugs and/or products I am currently ingesting or using topically. I understand my Technician 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 Technician 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 Technician 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 Technician or Rejuvenation Spa & Laser Services 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's Name _____ Date _____
Print

Client's Name _____ Date _____
Signature

Technician _____ Date _____
Print