



Clients Personal Information Chart

Full Name Date

Street Address

Postal Address

Tel

Email

Date of Birth Cell

	Y	N	Additional Comments
1. Have you ever had a wax?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Are you taking Retin A, Accutane, Glycolic Acid, A.H.A Skin Care or any other similar products that effects the skin?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Have you recently had any type of chemical or glycolic peel?	<input type="checkbox"/>	<input type="checkbox"/>	
4. If glycolic, what percentage? If chemical, please explain	<input type="checkbox"/>	<input type="checkbox"/>	
5. Do you have any allergies?	<input type="checkbox"/>	<input type="checkbox"/>	
6. Do you have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	
7. Have you had surgery in the past 3 months or dermabrasion?	<input type="checkbox"/>	<input type="checkbox"/>	
8. Are you taking any antibiotics or medication? If so, please list all (including over thr counter drugs/herbal supplements):	<input type="checkbox"/>	<input type="checkbox"/>	
9. Are you using any skin thinning products and/or drugs?	<input type="checkbox"/>	<input type="checkbox"/>	
10. How would you rate your sensitivity to pain?	<input type="checkbox"/>	<input type="checkbox"/>	
11. Do you have any moles, warts, abrasions, skin irritations or skin inflammations in the areas to be waxed?	<input type="checkbox"/>	<input type="checkbox"/>	
12. Have you been exposed to any tanning method in the past 24 hours?	<input type="checkbox"/>	<input type="checkbox"/>	
13. Are you exposed to the sun on a daily basis or are you considering spending more time in the sun soon?	<input type="checkbox"/>	<input type="checkbox"/>	
14. Please describe your current skin condition.			
15. Have you had any bad waxing treatments? If so, when and with what products, the more detail the better.	<input type="checkbox"/>	<input type="checkbox"/>	

Female Clients: When is your next menstrual cycle due to begin? _____
 (Always allow five days for menstrual cycle. Because of water retention and for your own personal comfort, you should avoid hair removal two days before your cycle is due and two days after it is completed.)

In an effort to make your waxing experience as comfortable as possible, please supply your wax technician with all the necessary details in regard to past waxing procedures or health information not requested on this form.

Customer Signature _____

After Care and Recommendations

(Please check each point to ensure you understand these recommendations)

- Apply a sunblock with an SPF of at least 15
- Avoid use of a loofah or other abrasives to the waxed area (within 24 hours)
- Avoid sauna, steam room, whirlpool bath or other heat source (for 24 hours)
- Avoid application of Retin-A, AHA product or other exfoliant product for 48 hours before and after waxing
- Avoid all irritating chemicals such as chlorine pools, perfumes, fabric softeners, deodorants (for 24 hours)

Contraindications/Cautionary Conditions

The following is a list of contraindications to waxing services which will make this waxing appointment inadvisable or may result in certain body areas not being waxed. Your esthetician will review these with you prior to your treatment.

Please check if you do any of the following (Y- Yes, N- No). Please give details where necessary.

	Y	N	Additional Comments
1. Broken Skin, Open Cutes, Pustules or Papules?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Inflammation?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Bruises?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Sunburn?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Rosacea/Very Sensitive Skin?	<input type="checkbox"/>	<input type="checkbox"/>	
6. Recent chemical peeling?	<input type="checkbox"/>	<input type="checkbox"/>	
7. Recent Botox/Collagen Injections?	<input type="checkbox"/>	<input type="checkbox"/>	
8. Cosmetic/Reconstructive Surgery?	<input type="checkbox"/>	<input type="checkbox"/>	
9. Suspicious Growths/Moles?	<input type="checkbox"/>	<input type="checkbox"/>	
10. Phlebitis/Swelling – Lower Legs?	<input type="checkbox"/>	<input type="checkbox"/>	
11. Fragile Capillaries/Varicose Veins?	<input type="checkbox"/>	<input type="checkbox"/>	
12. Flat Moles?	<input type="checkbox"/>	<input type="checkbox"/>	
13. Blood Thinning Medications?	<input type="checkbox"/>	<input type="checkbox"/>	
14. Please describe your current skin condition.	<input type="checkbox"/>	<input type="checkbox"/>	
15. Have you had any bad waxing treatments? If so, when and with what products, the more detail the better.	<input type="checkbox"/>	<input type="checkbox"/>	

I hereby release this establishment from

The hair removal procedure and after care have been thoroughly explained to me and I have had the opportunity to ask questions and receive satisfactory answers. I understand that because of certain health conditions, epilation services may not be advised.

I also understand that there may be swelling or irritation in waxed areas and that this may only be a temporary condition. I am of lawful age and have read and fully understand and have completed the content of this document to the best of my knowledge and represent myself as physically capable of using the service offered by this facility.

Customer Signature _____

Date _____