

CLIENT WAXING ASSESMENT FORM

NAME: _____

DATE: _____

ADDRESS _____ CITY: _____ STATE _____ ZIP _____

1. Have you been seen by a dermatologist? Yes ___ no ___ If yes, for how long?

2. Please list all medications that you take regularly. Include hormones and vitamins.

3. Do you have any allergies? Are you allergic to any medications? Yes ___ No ___ If yes please list allergies

4. Are you pregnant or lactating? Yes ___ No ___

5. Do you tan or visit tanning booths? Yes ___ No ___

6. Have you had any of the following procedures?

Laser resurfacing Yes ___ Date _____ No ___

Light chemical Peel Yes ___ Date _____ No ___

Medium/heavy chemical peel Yes ___ Date _____ No ___

7. Do you ever experience tightness or flaking of your skin? Yes ___ No ___

8. Do you have a history of fever blisters or cold sores? Yes ___ No ___

RELEASE FORM FOR HAIR REMOVAL

I, _____ AM NOT PRESENTLY USING:

_____ Retin-A, AHA's, Glycolic acid or any other topical vitamin A

_____ Accutane, differin or any other acne medication

_____ Any medications such as cortisone, blood thinners, or diabetic medication

_____ I understand that if I am using any of the above products and do not inform my esthetician prior to hair removal, I am accepting full responsibility for any skin reactions.

_____ The hair removal process had been thoroughly explained to me and I have had an opportunity to ask questions and receive satisfactory answers.

CLIENT NAME _____

CLIENT SIGNATURE _____

DATE _____

TECHNICIAN NAME _____

TECHNICIAN SIGNATURE _____

DATE _____