BODY/FACE WAXING TREATMENT

Name ____ _ Date _________

Address ______________________________________ City ______________________ St. _____ Zip ___________

Cell Phone __________________ Carrier _______________ Email ______________________________________

Emergency Contact _____________________________ Phone ____________________ Relation ________________

Date of Birth ___________________ Occupation ____

What body part/parts are we waxing today? ____

When did you last shave?____

How often do you shave?_________________ Wet or Dry (please circle) Shaving Cream?_____________________

Do you have tendencies to any of the following? Please check mark.

Ingrown Hair_____ Hyperpigmentation _____ Razor Bumps ______

Scarring _____ Bruising _____

Are you currently using or taking any of the following? Please check mark.

Accutane _____ Resorcinol _____ Glycolic Acid _____ Alpha - Hydroxy Acid _____

Retin-A ______ Scrub or peel of any kind ______

List all medications currently taking:____

I understand that waxing may cause bruises, scabs, scarring, redness, hyperpigmentation or pimples , and these are all normal reactions. I also understand that use of any of the above listed products increases the possibility of a reaction. If I start to use them or I am using them I must inform my technician before any waxing treatment.

Parent/Guardian Signature if under 18 years old____

Client Signature______________________________ Print_______________________________________ Date_______

Technician Signature__________________________Print_______________________________________Date_______